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WHAT IS MENTAL HEALTH?

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I

The problem is very simple to state: What has the main stream of the psychoanalytic tradition said about the nature of *health?* Are there norms for determining health as there are norms for determining sickness?

The word "health" comes from the Anglo-Saxon "haelth," meaning hale, sound, or whole. It is significant that health may be defined in two different ways: (1) as a *state* of being hale or sound in body, mind, or soul, or (2) as merely the *absence of disease.* The first definition is a positive "freedom *for*" life, and possession of strength of mind or body, whereas the second is a negative "freedom *from*" illness, or that which would rob one of strength of mind or body. Synonyms of health are wholeness (with its connotation of "oneness" as distinguished from brokenness), vigor (with its connotation of the ability to act), hardiness (with its connotation of the capacity for enduring stress or suffering), and soundness (with its connotation of a firmness which is securely grounded in a solid structure).

It hardly needs to be observed that *psychoanalysis has been more concerned with sickness than with health.* In fact, it has often been so exclusively concerned with the pathological dimension of man's existence that it has entirely ignored the question of the nature of a healthy relationship to existence. What is the implicit *norm of health* which lies hidden under its pathological analytic? Few have tried to make it explicit. Since its

theory has been rooted in therapy, and since therapy *per definitionem* is concerned with sickness, the question of the nature of health has been almost systematically neglected. Health has been defined merely in the negative sense, as the absence of disease. The positive definition of health has been left to the status of vague inferences and indirect generalizations.

II

What norms of health, if any, underlie the Freudian analysis of personality? One suspects that Freud tried very hard, and perhaps very successfully, to avoid facing and answering this problem. His therapeutic concern had its back turned to this problem. He dealt with the allegedly greater problem of the anatomy of neurosis. Only rarely in his writings does he speak of the *telos* of his therapy. Are we forced, therefore, merely to speculate about what Freud thought? Or, more precariously, are we forced to try to create out of the bits and fragments and negations of Freudian theory some positive, constructive theory of health?

Another methodological alternative is open to us which may yield more valuable conclusions, and may more truly reflect Freud's view. Let us try to identify the hidden confession about the nature of man which underlies Freud's relentless inquiry into pathology. Is there an implicit confession of what man *ought to be,* or the nature of the good life, which silently undergirds his analysis of sickness? In asking this question, our attention is turned not to the periphery but to the heart of Freudian theory and therapy.

At the center of the Freudian analysis of personality lies the axiomatic observation (with no small amount of passionate faith behind it) that the repressed and unseen unconscious, which determines most of the conscious activity of the self, is moulded or "set" by the sexual relatedness of the infantile history of the self.[1] Does this axiom immediately confess anything about the nature of health? Quite so, for even on the simplest level of understanding of this observation, one must conclude that *one is a healthy self who inherits from the early history of his infant self a kind of sexual relatedness to significant persons which does not fixate him at some premature kind of relatedness.*[2] Likewise, the unhealthy grown-up person is one who was unable to move through the early stages of sexual (and therefore ontological) relatedness successfully. Thus, health is determined, limited, or made possible by the ability of the infantile self-structure to cope with the reality it knows, which is chiefly explainable in terms of erotic attraction and contact.

This is a start. But have we yet identified a Freudian norm of health? No, this is merely a relatively fixed limitation on health. What is the *health*

[1]Sigmund Freud, *History of the Psychoanalytic Movement,* Part III, from *Basic Writings of Sigmund Freud.*
[2]Sigmund Freud, *Three Contributions to Theory of Sex,* Part II, "Sex Latency of Childhood," from *Basic Writings.*

which early sexual relatedness limits, determines, or makes possible? Infantile sexuality is a determinant of health, but what are the characteristics of the phenomenon "health" which infantile sexuality determines?

Freud thought it impossible to understand the self apart from its personal history.[3] Prior to understanding the health of a self, one must posit both (*a*) the uniqueness of each self and (*b*) the special importance of past significant events in the unique history of the particular self. Before one can make out appropriate goals for a particular self, he must know this personal history. This makes it difficult to construct a Freudian doctrine of health and apply it in terms of widely variant personal histories.

It is undeniable, however, that Freudian therapy intends to enable the client to "adjust better" to the human situation, to "learn to deal more effectively with his environment," to "fulfill himself," to make him "happier." What are the fundamental values which underlie these valuational terms such as "adjust better," "happier"? Such a valuational criterion might rightly be termed the "hidden faith" of Freud which underlies his scientific quest. It is not impossible to identify this valuational criterion. Here is the heart of its *credo: He who can compromise his libidinal thrust with his given cultural environment in some way in which neurotic anxieties can be minimized and libidinal expression be maximized, such an individual is "healthy."*[4] The goal of therapy is to enhance this compromise, or move the client closer toward this compromise.[5] As becomes apparent in *Civilization and its Discontents,* however, this reconciliation is never perfect, because of the inherently antithetical make-ups of the culture and the self.[6]

III

For Alfred Adler, an early revisionist in the Freudian tradition, one approximates the state of "health" in that degree to which one is able *to cultivate and maintain some certitude that one is really important in the scheme of things, without letting this feeling dominate his personality to the point of being out of line with reality, or the way other people view his importance.*[7] To fall on either side of this balance is sickness.

In his book, *The Neurotic Constitution,* Adler describes health as the movement "upward" from the feeling of "being beneath" to the feeling of "being above," *unless* this movement goes too far and becomes fantasy.[8] Manifestations of the feeling of "being above" (masculinity) include joy, victory, knowledge, wealth, art, and self-esteem, whereas manifestations of the feeling of "being beneath" (femininity) include such feelings as

[3]Sigmund Freud, *The Development of the Sexual Function,* cf. Clara Thompson, *Outline of Psychoanalysis,* pp. 90ff.
[4]Sigmund Freud, *Civilization and Its Discontents,* pp. 26-29.
[5]*Ibid.,* p. 123.
[6]*Ibid.,* pp. 40f .
[7]Alfred Adler, *Problems of Neurosis,* p. 33.
[8]Alfred Adler, *The Neurotic Constitution,* p. 73.

uncertainty, discomfort, impotence, disorientation, want, and fear of death.[9]

Adler thought that the feeling of "being beneath" was written into the child-situation. The child grows up with feelings of inferiority. They drive him toward attempting to actualize feelings of "being above." The healthy person is he who actualizes these feelings, without allowing his estimation of himself to become fantastic.[10] Adler's whole interpretation of neurosis, unlike Freud's, hinges on the notion that "guiding fictions" which normally help one in overcoming inferiority are accentuated and exaggerated by the sick person until they become distorted in terms of objective reality, and one's self-estimation does not coincide with the shared judgments of others.[11] Adler's fundamental departure from Freud was his view that sexual strivings were a category of superiority strivings,[12] whereas Freud thought the opposite.

IV

The first figure in the early psychoanalytic tradition to spell out fairly clearly *the goal of therapy* was *Otto Rank,* whose book, *Will Therapy,* Chapter 2, gives even an unfamiliar reader an introduction to his perspective. For Rank the crucial thing that occurs in therapy is not in the sphere of the intellect or the understanding, but in the sphere of the will. The accuracy of the therapist's diagnosis is much less important than what goes on in the interior will of the individual.

> It is neither the infantile (Freud), nor the guiding purpose (Adler), nor the unconscious made conscious (Jung) that counts, but the therapeutic experience itself.[13]

Rank rejected Freud's biological determinism on the grounds that it ignored the possibility of individuation and self-determination, and that it neglected the fundamental definiendum of health, *viz.,* the will. He spoke of "our abolition of the fact of will"[14] in modern scientific society. He regarded this as the central problem not only of psychoanalysis, but of life. He protested that conception of therapy which placed ultimate importance on the decisions of the therapist and kept the patient's own expressions of will in the background. He conceived of the goal of therapy as that of giving the patient a chance to make a positive expression of his will and a positive self-determination of his life-goal.

> The goal of constructive therapy is not the overcoming of resistance, but the transformation of the negative will expression . . . into a positive and eventually creative expression.[15]

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[9] *Ibid.,* pp. 51ff.
[10] *Ibid.,* p. 1.
[11] *Ibid.,* pp. 29, 61.
[12] Alfred Adler, *Problems of Neurosis,* p. 29.
[13] Otto Rank, *Will Therapy,* p. 9.
[14] *Ibid.,* p. 24.
[15] *Ibid.,* p. 28.

Health is the acceptance of one's own freedom, and sickness is the flight from freedom and self-affirmation.[16]

> Finally, therefore, everything depends on the attitude of the particular individual . . . primarily toward himself. In the last analysis therapy can only strive for a new attitude toward the self, a new valuation of it in relation to the past, and a new balancing in relation to and by means of, present reality.[17]

Rank's clearest statement of a norm of health is found in *The Trauma of Birth,* in which he understands neurosis to be an unconscious protest against the insecurity and threat of the post-uterine situation and a longing for the former untroubled situation of the mother's womb.[18] *Health* is the *willingness to be born,* again and again, without incurring the burden of *guilt* in the process of being born. Guilt arises from one's being separated from the source of love. Health involves arising from dependencies to the *affirmation of one's own will,* and the willingness to live as a guilty man (guilty for breaking away from the mother figure) in the midst of the contradiction of freedom and guilt.[19]

V

In suggesting that the positing of neurosis implicitly involves the positing of a concept of normalcy,[20] Karen Horney has made some valuable contributions to a theory of health, among which are:

1. The element of cultural variation which qualifies any attempt at universalizing a norm of health. Unlike Freud and Jung, who also made cultural and anthropological studies, but did so from the *a priori* point of view of Western cultural norms (and thus did not perceive the normalcy-abnormalcy criteria from the "inside" of each particular culture), Horney saw in cultural relativism an important clue for both therapy and theory.[21] She suggested that "normalcy" was objective only in the province of a particular culture, and that this objectivity was rooted in the particular subjective point of view of the culture. To presume that there is some non-historical, supra-cultural, universal definition of health (or neurosis) is to ignore the remarkable witness of cultural anthropology.[22] It is for this reason that Dr. Horney has often been referred to as a "cultural analyst."

2. In spite of the absence of a supra-cultural norm, she nevertheless seems able to use the terms "normal" and "abnormal" as synonymous with healthy and neurotic. The chief features of the healthy personality are objectivity and flexibility. The healthy person is able to stand in the

[16] *Ibid.,* p. 272.
[17] *Ibid.,* p. 290.
[18] Otto Rank, *The Trauma of Birth, Passim.*
[19] *Ibid.,* p. 190.
[20] Karen Horney, *The Neurotic Personality of Our Times,* pp. 17ff.
[21] *Ibid.,* Chap. 1.
[22] Karen Horney, *New Ways in Psychoanalysis,* pp. 168-171.

objective situation and see it as it "really" is, and choose his mode of response in the light of this, without bringing to the situation prior neurotic patterns which interpret the situation. The abnormal person interprets the situation in the light of a predetermined perspective of anxiety and hostility, and whatever he sees in the outward situation is "fitted into" his pre-set understanding. He is more rigid in his action because he has to take this back-door approach to reality and cannot flexibly change as the objective situation changes.[23]

3. Dr. Horney placed almost exclusive emphasis on the present situation of the patient, breaking radically with the classical Freudian theory, in her understanding of the therapist's role in helping the client move toward health. Earlier theorists had understood the infantile history as the great architect and absolute limiting factor to mental health, whereas Horney emphasized not the past history but the present self-understanding of the person.[24] She voiced more optimism concerning the human capacity to correct its past infantile distortions and gain release from sick patterns of behavior. Thus her theory of therapy contains an implicit assumption about the nature of mental health. It seeks to correct the Freudian pessimism regarding the ability of the self to rise above the absolute limiting factor of the infantile "set" of normalcy or abnormalcy.[25]

VI

The root of our difficulty in attempting to establish reliable psychotherapeutic norms of health, according to Erich Fromm, is that we have unwittingly persisted in measuring individual health by a sick culture, presuming all the while that our society was "normal."[26] That latter-day Western culture is unhealthy and disintegrated is demonstrable,[27] and to shape a personality in its image is disastrous. Thus Fromm asserts that much of the implicit *telos* of therapy has been ill-conceived and uncritical.[28]

Fromm's view of health includes these factors:

1. To be able to deal with the existential contradictions which are given in and with human existence is a chief sign of the integrated self. No man can avoid being both finite and free, and yet his finiteness and his freedom strive against each other. It is impossible that he return to the determinism of animal existence.[29] The very human situation is defined by unalterable existential facts which pull the human spirit asunder: man wishes to escape the burden of his freedom and yet he is unfree to be anything except free. Unlike the beast, man knows what it means "to die," and yet he cannot alter the fact of death or in any way avoid it.[30] The

[23]Karen Horney, *The Neurotic Personality of Our Times,* pp. 181ff.
[24]Karen Horney, *New Ways in Psychoanalysis,* pp. 146f.
[25]*Ibid.,* Chaps. 1 and 2.
[26]Erich Fromm, *The Sane Society,* p. 3.
[27]*Ibid.,* pp. 12-21.
[28]*Ibid.,* p. 6.
[29]Erich Fromm, *Man for Himself,* p. 39.
[30]*Ibid.,* pp. 41-42.

dichotomies of bondage/freedom, flesh/spirit, finite/infinite, irrationality/reason, perception/imagination confront him each moment of his existence. Whether he reflects adequately upon them or not, he deals with them, since this is what it means to be a man—to be placed in the midst of these existential dichotomies.[31] Therefore, norms of health for the human situation are not to be sought in some theoretical periphery of man's existence, but at the very center of the human problem—freedom's struggle to be free, which *eo ipso* is a paradox. Health, according to Fromm, is a way of relating oneself to the world and to oneself in which one is able to deal productively with the existential dichotomies which inhere in the human situation. But "productively" is a value word. What lies behind it, according to Fromm?

2. *The productive character orientation.* The basic need of man, far transcending the instinctual needs of animal existence, is for a "frame of orientation and devotion," or a structured (though flexibility must be possible within this structure) view of life in which one can relate himself to himself and his world, and thereby deal meaningfully with the contradictions of existence. The process of acculturation intends to provide one with such a view, but often fails. During the process of acculturation, however, the individual may acquire one of several "character orientations": receptive, exploitative, hoarding, marketing or productive.[32]

The productive character is he who accepts himself and his human situation, without excessive dependence upon or independence from others. He affirms his freedom and yet does so within limitations, and in doing so he is able to love. To love means to be "able to come into a creative union with someone or something outside himself under the condition of retaining the separateness and integrity of his own selfhood".[33] This union, paradoxically, strengthens his sense of individuation and self-determination.

3. Fromm also uses the process of individuation as a parable of the process of health. To become fully individuated, or "fully born," is to emerge as a free individual from the secure intrauterine situation (an important theme from Rank), able to use one's freedom creatively, invest it in love, and live with the sense of separateness and isolation which is the hidden side of freedom.[34] According to Fromm, the average American individual, submerged in economic activity, bound by every sort of dependency, almost totally manipulated by his surroundings, desperately seeking relatedness through chameleon-like conformity, is very far from being fully born, in this sense.

A healthy mode of being in the world is not, for Fromm, the same as the abstract concept "health." Health is not something "out there" by which if one understands and appropriates it he becomes "healthy." Rather

[31]Erich Fromm, *The Sane Society,* p. 25-27.
[32]Erich Fromm, *Man for Himself,* pp. 82ff.
[33]Erich Fromm, *The Sane Society,* p. 31.
[34]Erich Fromm, *Escape from Freedom,* pp. 29-35.

the creation of a meaningful and healthy existence is a creation of the existing self. It is not the gift of other selves, of a therapist, of God, or of nature. Meaning is chosen, and to be healthy is to choose to create meaning for oneself.[35]

VII

Although Carl Rogers is not and would not regard himself as being in the psychoanalytic tradition, he nevertheless has been in dialogue with it in the development of his distinctive views of therapy and psychological theory. His assumptions about the nature of health have been partially clarified in his book, *Client-Centered Therapy,* and especially in his paper "The Concept of the Fully Functioning Person."

1. That self is healthy in that degree to which he has been able to make the whole of his self-understanding available to awareness. The healthy self is "open to one's self." He does not "shut out" certain areas of awareness.[36] This does not mean self-consciousness, as a centipede's being aware of all its legs,[37] but an awareness of or listening to oneself as a total "I." The purpose of a therapeutic situation is to create an environment in which there is enough reduction of threat to the self-structure that the self is able to explore unexamined areas of experience and bring them to awareness.[38]

2. The individual is healthy, not especially when he has "solved" his "problems," but when he has developed enough strength in self-awareness to deal with all of life standing on his own two feet. The role of the counselor is not to examine the history of the self in such a way that the "real problem" can be diagnosed and explained, or even to direct the client to seeing the "real problem," but rather to create a

> definitely structured permissive relationship allowing the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation.[39]

Because of Rogers' assumption of the fact of genuine uniqueness in every personality, there is no "standard" formula by which a person might be defined as healthy from an objective point of view. It is conceivable that one healthy person would deal with a situation in a manner exactly opposite that used by another relatively healthy person.

3. One is healthy who deals with each present moment in what Rogers calls an "existential" attitude, which for him means letting the self fluctuate or flow with the surrounding experience, yet without letting the self be swallowed up by the environment. The self and experience are in a harmonic dialectic in which the mode of the self's response "emerges out of experience"

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[35]Erich Fromm, *Man for Himself,* p. 45.
[36]Carl Rogers, "The Fully Functioning Personality," unpublished paper, p. 4.
[37]*Ibid.,* p. 7.
[38]Carl Rogers, *Client-Centered Therapy,* p. 517.
[39]Carl Rogers, *Counseling and Psychotherapy,* Chap. 1, Sec. 3.

and yet changes the quality of experience, neither tyranizing over the other.[40] The dialectic of the self and experience is extremely important to Rogers' whole theory of personality and perhaps needs graphic representation. Picture two circles overlapping so that the circumference of each passes through the center of the other. Let the non-overlapping portion of the left-hand circle represent *distortion* of symbolization (subjective) and the corresponding portion of the right-hand circle represent the *denial* of experience (objective). Arrows drawn from each of these areas to the overlapping area indicate movement toward this latter area, or "center," which represents the area of integration and awareness. This diagram indicates that the self is healthy which has been able to bring into the area of integration and awareness both the prior distortions of the self-structure (subjective) and prior denials to awareness of certain experiences with the environment (objective) which were inadmissable because they were inconsistent.[41] After successful therapy the client feels that the center area is his "real self." Thus Rogers is led to affirm as healthy the movement toward the center.

4. An individual is healthy to the extent to which he is able *fully to function* as a person. The fully functioning person accepts his organism as a trustworthy means of moving toward and through the good life. He is able to live in and with all his feelings, to bring them into conscious awareness, and to react to the objective situation realistically and personally.[42] He accepts himself and "feels right" in situations just being himself. His behavior is dependable but not predictable.[43] Even an expert observer of personality cannot forecast the reaction of the healthy individual in the next moment, whereas the rigid, neurotic person is much more predictable.

Conclusion

The question which launched us into this inquiry was whether there were any implicit norms of health underlying the concern of psychotherapy for sickness and its cure. For Freud it was the balancing of the libidinal thrust with the cultural environment in such a way that anxiety is minimized and libidinal expression is maximized. For Adler it was the certitude of one's own importance within the limits of the way other people view one's importance. For Rank it was the willingness to be born, again and again, and the taking into oneself of the guilt which is incurred by the separation of being born, figuratively speaking. For Horney it is flexibility and objectivity within the unique frame of reference of one's own cultural situation. For Fromm it is the capacity to enter into relations with others without the loss of oneself as a separate and self-affirming individual. For Rogers it is the power of making the whole of one's self-understanding available to awareness.

In summary, the total tradition of psychotherapy speaks of health,

[40] *Ibid.*, pp. 7ff.
[41] Carl Rogers, *Client-Centered Therapy*, p. 526.
[42] Carl Rogers, "The Fully Functioning Personality," p. 11.
[43] *Ibid.*, p. 17.

in one way or another, as *self-acceptance,* self-affirmation, or self-realization. The differences that arise within this tradition are differences in the definition of the *self.* The remaining question, which this paper leaves unexplored, is: What is the Christian understanding of the self, if there is such, and what would follow from this as to the content of self-acceptance, self-affirmation, and self-realization as it is understood by the Christian community? Regrettably, we must leave this question for some future inquiry.

THE ADOLESCENT AND THE WORLD OF TODAY

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It hardly seems possible that anything new could be said about this topic since discussions of adolescents go back to the early Greek and Roman times and each age period was accompanied by the thought that the new generation was "going to the dogs." It would seem of value to look into this period of development in light of today's understanding of emotional development. This discussion is directed toward the understanding of the "normal adolescent." Adolescence is generally thought of as the period from the onset of physical and emotional maturity to full adulthood. We euphemistically label this period the "teen-age years" because it accidentally coincides with the teen numbers, namely, 13 through 19 years of age. It must be remembered, however, that although this period of growth and development is rapid and biologically determined, it varies from individual to individual with a distinct difference between boys and girls. Girls mature, on the average, two to three years earlier both physically and emotionally. Many parents eagerly await the development of their children from grade-school age to adolescence with the hope of accompanying maturity and better personality organization. When adolescence arrives, however, the parents soon find that there is little relief in store for them with the coming of this age period. In fact, in many instances, the parents wish the child were again younger. There is no question that the great amount that has been written about adolescence has been produced because adolescence is a period of uncertainty, concern, and turmoil for both the parents and the child. This is especially true if the parents have had no experience with adolescent development. Fortunate is the child who has a couple of older brothers or sisters who have prepared the way for his parents to act more rationally toward him when he enters this period. The parents' interest in having their young son reach a higher stage of maturity was exemplified in the story about the mother of a five-year-old son. One day the grandfather offered to take his grandson shopping and then to his home for a time. After they had arrived at the grandparents' home, the grandfather called the child's mother to ask when she wanted him back and received this answer: "When he is 16 years old."[1]

Adolescence can be a troubled time because of the parents' and child's

[1]David Riesman, *The Lonely Crowd.*

great uncertainty. Although this probably occurred to some extent in the past, it seems to be greater today because of the increased emphasis upon freedom, lack of rigid standards of behavior, and a general loosening of social mores. Yet, today as in the past, the adolescent's need for arriving at his own independence and emancipation is the same as always. Because of the lowered standards of behavior, there is greater doubt about the child's capacity for good judgment. Because the parents remember some of their own experiences, as well as the newspaper publicity about various kinds of adolescent problems, there is an increase in the parents' fantasies about all the bad things that can happen. On the other hand, the child's need to explore his newly won emancipation is underlaid with fear of his own adequacy. The parents' attempt to protect the child by too severe restrictions is met with rebellion. The fine line dividing healthy emancipation and independence from unhealthy rebellion and defiance is a constant concern to the parents. Frequently added to this is the parents' reluctance fully to realize that time is passing and to recognize that the child's maturity indicates their own advancing age. To keep the child young is to preserve the fantasy of their own youth.

Through all this, I would like to use as a focus the fact that certain work needs to be done to achieve emotional and personality maturation. By that I mean that the job of maturation involves certain goals and the work toward them by the adolescent is evident if one will stop long enough to look at them. This learning and experiencing process, unfortunately, is sometimes painful and frustrating. There is no healthy way for the parents to protect their children in adolescence from many of these painful experiences. It is unfortunate that each individual has to learn certain facts of life in much the same way as his parents did, and his parents' parents before them. This does not mean that parents are expendable at this age, but rather that they must gauge their dosage of controls, limits, support, and respect in a way that provides for this maturation process without interfering with it. Most of the qualities that are within an individual are there prior to adolescence—respect for good, capacity to love and have feelings for others, a sense of allegiance to family, and a capacity for withstanding pain and suffering in order to achieve a goal. If these qualities are lacking, adolescence is a rather unfortunate time to have to learn them.

Perhaps with this general orientation we can become more specific and examine in more detail the work and responsibility of maturation that faces the adolescent. Shakespeare, in his invariably gifted way, described it in these words: "I would there were no age between 10 and 3 and 20, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing and fighting." Thus Shakespeare epitomized three outstanding challenges which confront the adolescent—the sex drive, emancipation from parental authority, and the aggressive drive to achieve and dominate. To sleep out

these years would be one solution, but certainly not a very adequate one. Gaining experience and thereby mastery over the conflicts of each of these three areas is vital to arriving at a solution that is personally and socially acceptable. This is the goal of maturity, which knows no short-cut.

Taking up the problems of adolescence in relation to the three areas mentioned above, let us start with the problem of the biological sex urges and drives which frequently come upon the adolescent all to quickly and leave him or her frightened and uncertain as to what they mean and what to do about them. They are first felt as something not even entirely rational but just a feeling of confusion or strange body sensations resulting in undue blushing, feeling hot, feeling shy, and, in the case of a boy, experiencing a rapid heartbeat when he is placed in certain situations of proximity to a certain girl, or girls. This condition may be humorous to adults, but it is acutely uncomfortable for the adolescent. The confusion may not be understandable to the boy, because he may have had various kinds of social interactions with that girl or those girls throughout several preceding years, and suddenly, with the same girl or girls, all these strange feelings arise within him. We see, then, that the first response to sexual feelings in the young adolescent is an acute awareness of his body in terms of the above-mentioned feelings. He soon recognizes that these are related to the stimulus of girls for whom he has some feeling. This, of course, leads to a desire to be more attractive and calls forth the first response of interest in grooming. If, on the other hand, these feelings are too overwhelming and frightening, the young adolescent boy may attempt to handle them by avoidance and actual sloppiness in physical appearance to provoke the hoped-for rejection and thereby avoid the stimulation of the frightening feelings. These strange feelings can lead to a certain hypochondriacal attitude which is substantiated by the fact that the body is growing rapidly, with a resultant clumsiness and an uncertainty of just where his extremities are. As these feelings about himself are repeated and as they are recognized as feelings toward the opposite sex, they run into certain contradictions and taboos in relation to his earlier beliefs. His spontaneous fantasies frequently will lead to an interest in what girls are like, a fascination with fantasies of what girls are like unclothed, which is sometimes supported and stimulated in the older adolescent by his seeing literature, books, and magazines which further arouse his curiosity. His learned taboos and feeling of wrongness in being interested in such things leads to self-condemnation and an attempt to control these unwelcome ideas by a strong attraction to idealism, perfection, and strengthening of religious attachments—or abandonment of these if religion has not meant much to him. Guilt is further provoked by an emerging awareness that with physical growth occurs pleasurable sensations in his genital area, an experience which is contrary to his earlier teaching and substantiates his feeling of being bad and wrong. A fear of punishment and bodily harm is readily accepted by the adolescent as a type of self-punishment. Such fantasies consist of a fear that his body is being harmed, that he is becoming weak,

or that his vision is being affected, which adds to the already present hypochondriacal tendencies. During this same period, the boy is greatly interested in physical development and is a very easy prey to all the fake physical culture ads.

The girl, having similar feelings, has a great interest in methods of making herself beautiful and falls an equally easy prey to all the beauty culture and charm school ads. It is with the intensity of these conflicts that participation in learning is decreased, and so school grades frequently fall temporarily in the seventh and eighth grades and the first year of high school. It is also during this period that the child is hypersensitive, may weep easily for reasons not apparent on the surface, and tends to be more seclusive.

The second area of experience and development necessary for maturity was labeled by Shakespeare's "wronging the ancientry." By this is meant emancipation from parental authority. This is the work that is necessary to the adolescent to prepare himself for independent living and functioning. This drive for independence may be noticed first as the child turns away from his parents as guides to behavior, dress, etc., and turns to his peer group for direction in these matters. The parents are regarded by the child at this age as being slightly stupid. As was once quoted in the *New York Times* under a title of, "You Can't Win":

> According to one father, his family consists of three members: nobody, everybody, and anybody who is anybody. When a difference of opinion arises, says the father, his teenage daughter invariably prefaces her remarks with, "Anybody who's anybody knows that . . ." His wife usually claims that, "Everybody knows that . . ." His own opinion, he reports, is usually met with a chorused, "Nobody believes that these days."

It is at this time, then, that the distinct separation of generations becomes manifest. The new generation is re-evaluating all that has occurred and is occurring in the light of their own goals and ideals. It is the questioning of facts and statements that had previously been believed without question or critical evaluation. Now nothing is true unless it is proven or self-evident. This learning to think for oneself may create a serious strain on the parent-child relationship. They are the wise parents who can keep themselves from over-reacting to the seemingly defiant attitude in their previously pleasant, agreeable child. It takes a certain amount of strength and a capacity for independence for the child to begin this process of emancipation, and no child is immediately able to undertake this alone without fairly strong feelings of uncertainty, aloneness, and the need for support from someone. It is at this time that the adolescent turns to his peer group, and one of the vehicles of this "turning toward" is the telephone. Although the adolescent does not realize it, the prolonged telephone conversations so notoriously prevalent at this age, are attempts on his part to compare his feelings, to be reassured that someone else is having the same feelings that

he is, to gain strength from the viewpoint of another person, and, in a sense, to cling to that other person in this sea of loneliness. It can never be but a source of amazement to parents that an adolescent girl, who has left her girl friend only fifteen minutes before, will, upon entering the house, rush to the telephone to call that same girl friend. This behavior usually disappears as the adolescent gains mastery of his feeling of aloneness and gains courage and security in his capacity for independence. It would seem from the adolescent's reaction that parents are unnecessary at this point, and, because of the parents' feeling of rejection, they will try to compensate by being overly solicitous and generous to their son or daughter. The child does need the parent to maintain the same rules, regulations, and standards of behavior and all that went into the child's family life prior to his entering adolescence.

An amusing example of this situation was reported by Irene Josselyn.

> A mother consulted a psychiatrist because her 14-year-old daughter, she felt, was quite disturbed because she was so resentful of her mother and father. It came out that the mother was directing the daughter very much as if the daughter were a small child. It was suggested she allow the daughter more freedoms since it seemed the hostility of the daughter arose out of the mother's infantilizing attitude. The mother tried this and reported later that she was now completely confused. Upon arising in the morning, Mary had called to ask what dress she should wear to school. Without thinking, the mother said "The blue one." Mary became angry, saying, "That's a ridiculous choice, people don't wear such clothes to school." Why couldn't her mother be like other mothers, they didn't dictate what their daughters wore, etc., etc. The mother, recovering from the attack, remembered her talk with the psychiatrist, so that evening Mary was to go to a party. Again Mary asked her mother what she should wear. This time the mother remembered the psychiatrist's advice and told Mary to wear what she wanted to wear. Mary became indignant. "Why couldn't she have a mother like other mothers? After all, Mary didn't know how one was supposed to dress. Her mother went out socially and knew what was proper. No wonder she felt funny when she went out. Etc., etc." Mary's mother finally resigned herself to the fact that the normal mother of an adolescent is always in the reverse phase of the normal adolescent.[2]

Of course this is not really true, although many times it seems to be. The adolescent needs consistency on the part of the parent even though he does not always comply. Inconsistency may be likened to a situation in which two people are approaching each other and both turn in the same direction. Someone has to maintain a straight course to offer the necessary stability—and to avoid a collision.

The third area of work on the road to maturity is described by Shakespeare as "stealing and fighting." This is related to the struggle in peer

[2]Irene M. Josselyn, *Psychosocial Development of Children.*

group relationships and essentially is the expression of an aggressive drive to dominate and succeed. Competition, of course, is present in the pre-adolescent child, but in the child it is focused on achievement in order to look better, to be loved more, or to gain other satisfactions from the parents or parent equivalents. With the emergence of adolescence, the urge to achieve is no longer so much in relation to the parents as it is in relation to the peer group. Now the group will set its own ideals and standards and these may be contrary to those of the parents. Some adolescent groups may, for example, come to a mutual agreement that everyone will do average work in school. Anyone who exceeds this standard is looked upon as a "square" and loses status. In the place of this standard, standards of daring and risk may be set up. These may take the form of staying out late at night, driving a car too fast, violating the social code by petty thievery —behavior that in some instances takes on the aspect of initiation rites. All of this, of course, is manifested through the great quantities of energy that the adolescent has. The good judgment of the group is ordinarily not lost unless there happens to be an individual or two who may have strong delinquent urges and so influence the group that they exceed their good judgment. Such an influence may be effective for a short time, but invariably results in breaking up the group.

Out of this struggle with sexual feelings, for emancipation from one's parents, and the desire to achieve and dominate comes the strengthening of the ego with the ability to use good judgment, to be flexible, and to master social and instinctual conflict. There are several devices which are commonly used by adolescents to help them toward their goal of maturity. It is helpful if parents know and foster the use of these devices. The use of adolescent idealism and desire for perfection has already been mentioned. The adolescent strives to use these as an amplification of his pre-adolescent concepts. Although it is an attempt to deny his or her biological instincts, it does not completely do so, and, as the adolescent sees that some things are ideal and some things are less than ideal and that life really is made up of a mixture of all kinds of elements, he can give up the rigidity of his idealism. Adolescent idealism then can be thought of as a way-station that plays a vital role as an island of security from which the world may be examined to discover the true state of affairs. It is the inconsistencies of the adult world that are so confusing to the adolescent—the pious churchman who has questionable ethical standards of business practice, the national scandal of payola and rigged quiz shows, union dishonesty and corruption. All these have a much greater impact on the adolescent than on the average adult who takes this kind of thing in stride, realizing that life is made up of various kinds of inconsistencies.

A second device that plays a large role in the adolescent's achievement of maturity is the use of hero worship. Every adolescent who gives up the closeness to his family begins to wonder who he is, what his capabilities are, and, in searching for a model partly to fulfill his ideals, becomes

interested to varying degrees in a hero. The development of hero worship provides a strength for guiding behavior, thinking, and understanding. The traditional heros are, of course, well known, starting back with George Washington, leading to those who settled the frontier such as Buffalo Bill and Davey Crockett and the beloved Lincoln, who arose from poverty and social insignificance to a position of power and importance. Hero worship provides a belief that things will turn out all right and that success will come only if one is persistent enough, and thereby it provides a stimulus for dedication.

A third area of strength for the adolescent is a use of group ideals. Although at times these may seem strange and even objectionable to the adult, they provide a framework of support for guidance in behavior which, even though temporary, is necessary. At times, group ideals may exceed that which is socially acceptable, for some adolescents, because of deeper personal psychological problems, may select a hero such as Dillinger or Al Capone. Invariably these are the great minority and usually require special understanding.

The fourth area of strength for the adolescent lies in testing and exploring his or her feelings for the opposite sex through admiration from a distance. This is the phenomenon that occurs when the adolescent boy or girl becomes infatuated with a movie actor or actress. Much time is spent romanticizing in fantasy, exploring the feeling that might occur should this or that situation happen. This provides an opportunity to experiment with feelings of attraction toward the opposite sex. In this way the adolescent learns to manage and get accustomed to these feelings before trying out some of them with those he really knows and who are close to him or her.

A fifth way for the adolescent to help himself achieve maturity is through participation in worthwhile activities. In this area lies one of the major weaknesses in our urban and suburban societies today. We feel that we have provided all that is necessary when we build and support a recreation center. Recreation, important as it is, can never substitute for the feeling of making a contribution, of beginning to take his place in society and bearing a part of the responsibility that constitutes society. Our federal and state work laws have done a very effective job of preventing exploitation of child labor, but they have robbed the adolescent of an opportunity to begin participation in worthwhile social activities. Part of the adolescents' uncertainty and feeling of worthlessness comes about because we regard them as currently unable to do anything worthwhile. The accumulation of rage and frustration at being ready to do something worthwhile but deprived of the opportunity to do it has its outlets in fast driving, staying out late, bragging about various exploits, etc. Such behavior is but an attempt to make up for the very strong feeling of worthlessness. It would be very helpful if the older adolescent could have the opportunity for temporary apprentice-type relationships with a shop owner, in industry,

on the farm, or in forestry and wildlife management. Of course, there are a few opportunities of this kind offered in private, but they are very limited because of the employment laws as well as the complexity of, and competition in, business.

All of today's adults have gone through the phases of adolescence and have integrated in one way or another the experience associated with them. The way in which they integrated these experiences has much to do with the mature personalities of these adults, just as the manner of integration will affect the personalities of today's adolescents, who will be tomorrow's adults. Delayed integration of the various phases or delayed resolution of the problems involved results in behavior unbecoming to an adult and interferes with adjustment to adult life. On the other hand, integration and resolution of these situations as they arise, i.e., during the adolescent period, lead to mature behavior in the adult and increase the likelihood of a satisfactory adjustment to adult life. This points up the fact that all efforts made by those in a position of authority— parents, pastors, teachers, physicians—to aid the adolescent by understanding his personality growth struggle result in the greatest likelihood that each individual will fulfill the goal of his childhood, i.e., he will become a mature person physically and emotionally.

ATTITUDES OF MENTAL PATIENTS AND STAFF TOWARD A CHAPLAINCY PROGRAM

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The spiritual needs of the hospitalized mentally ill until very recently were met by clergy of local churches.[3] The services rendered were quite limited, often being restricted to preaching Sunday sermons, visiting the sick, and participating in burial ceremonies.

Major changes have occurred in the past twenty years. The Association of Mental Hospital Chaplains (1) has 408 members in 1960, including part-time as well as full-time personnel. The functions of these individuals have greatly expanded and now include pastoral counseling, training of clinical pastoral interns, participation in interdisciplinary planning, and many other activities.

Expansion of the roles and functions of one discipline is likely to conflict with other departments' goals and expectations particularly in large organizations in which communication channels are often inadequate to meet all the demands placed upon them. Hiltner (2) states that "in 1941 an anonymous questionnaire study of physicians and ministers who worked in several Protestant hospitals showed startling ignorance on the part of each of the real function of the other," but concludes that by 1956 "a climate has been established in which both cooperative work and respectful discussion may take place."

The purpose of this study is to assess objectively the attitudes of hospital personnel and patients toward an expanding chaplaincy program. Other considerations are to give patients and personnel the opportunity to indicate the functions and activities of chaplains they feel are of most value. This survey is considered as action research inasmuch as the results may alter the future development of the local chaplaincy program.

Method

Instrument. The first step in this study was the construction of

[1]The authors wish to thank George A. Bowdler, Jr., William M. Major, and Collie L. Moore for their assistance in constructing the questionnaire. We are also indebted to Theron V. Smith for his help in analyzing the data.
[2]Dr. Gynther is now Director of Psychological Services at Malcolm Bliss Mental Health Center, Washington University School of Medicine, St. Louis, Missouri.
[3]There were exceptions, such as South Carolina State Hospital which had a full-time chaplain as early as 1877.

a questionnaire, as none was available in the literature for measuring attitudes toward a chaplaincy program. Constructing the questionnaire was essentially a group activity. Four chaplains were asked to write down all the statements they felt were related to the subject matter. In this manner approximately 80 true-false type items were obtained. These were analyzed by the chaplains and the authors and reduced to approximately 25 by eliminating duplications, tangential items, and the like. By means of the same general procedure, five multiple-choice items and three open-ended questions were obtained. The questionnaire prepared for staff members was modified slightly for use with patients.[4]

Subjects were asked to indicate their agreement or disagreement with each of the 25 true-false type items by selecting one number on a seven-point scale. Thus, +3 indicates "I agree very much" and —3 means "I disagree very much." Some of the items are negative with regard to chaplains and their programs and other items are positive. Agreement with the negative items results in a high score (e.g., +3 is equivalent to 7). The remaining statements, with two exceptions, are positive with respect to chaplaincy. Agreement with these items results in a low score (e.g., +3 is equivalent to 1). (Omissions, "don't knows," and zeroes received a score of 4.) Total possible score ranges from 10 to 70, with a low score indicating a liberal attitude which favors growth and development of the chaplaincy program and a high score indicating a conservative attitude with marked resistance to change and expansion.

Two items—"I am a very religious person" and "Employees should encourage patient participation in the Sunday services"—were not scored. The reason for their inclusion in this scale was to permit analysis of the results with reference to the rater's degree of participation in religious activities and his attitude toward supporting and encouraging patient's entering into religious activities. These items may not tap the same attitudinal dimensions; that is, agreement with the former item may signify that the subject would approve of the activities of chaplains and religious institutions in general as a function of his personal commitment, whereas a positive rating of the other item may simply mean that the person, in recommending religious activities for others, is subscribing to a culturally valued symbol, like mother, home, and the American flag.

Subjects. In order to get a relatively unbiased sample of staff and patients' attitudes at South Carolina State Hospital, the authors decided to obtain population values where possible and relatively large samples where the size of the population rendered total assessment impractical.

Staff was categorized in terms of professional status. Four groups resulted, namely, physicians, registered nurses, aides, and medical auxiliary. The latter group included psychologists, music therapists, occupa-

[4]Copies of the two forms of the questionnaire may be obtained by writing the authors at South Carolina State Hospital.

tional therapists, librarians, etc. Including both white and Negro divisions of the hospital (i.e., Columbia and State Park), there were 29 physicians, 61 registered nurses, 39 medical auxiliary, and over 700 aides. It was decided to send questiannaires to all physicians, nurses, and medical auxiliary, but to obtain simply a 10 per cent random sample of the aides. This percentage value resulted in the selection of 73 aides.

The selection of patients for this study raised many problems. As there are more than 6000 in the hospital, selection of a large proportion was clearly out of the question. If we concentrated on any one group (i.e., Admissions Building) the sample would obviously be non-representative of the patient population-in-general. If we surveyed only men, we could say nothing about women's attitudes; if we contacted only whites, we could say nothing about attitudes of Negroes; and so on. We decided, first, that a sample of about 10 per cent would be of sufficient size and still be manageable. Then we decided to include both races and both sexes. Finally, we concluded that we should have both open and closed ward patients, reasonably matched in terms of age and condition. To meet all these criteria, 16 buildings were selected: half at State Park, half in the Columbia division, half with male patients, half with female patients, half closed, half open. The matching feature was made possible by means of the junior author's extensive knowledge of the patient population, gained by working at this hospital more than 25 years.

Procedure. Questionnaires were sent via interdepartmental mail to staff members who had been selected as subjects. On two subsequent occasions reminders were sent to those staff members who had not yet returned the forms.

A somewhat different procedure was necessary with the patients. For one thing, it was anticipated that not all patients receiving questionnaires would be able to comprehend the instructions. Also, it was felt that some patients' conditions would interfere with their filling out the form. Consequently, head nurses and charge aides on the buildings involved were asked to explain the questionnaires to the patients and see that those who needed help got it. These cooperating staff members were also asked to put an explanatory note on the questionnaire when it could not be completed (i.e., patient refused, etc.).

Anonymity was guaranteed, the subjects merely being asked to check the categories (i.e., staff or patient, white or Negro, etc.) which were given on the last sheet of the questionnaire.

Results and Discussion

Response to the Questionnaire. Of the 202 questionnaires sent to staff, 135, or 66.8 per cent, were returned. Of these, 8 were unscorable due to subject error, leaving 127, or 62.9 per cent, usable questionnaires out of the total sent out. Wide differences in percentage return occurred, if the returns are analyzed by the categories mentioned earlier. For instance,

76 per cent of the aides at State Park returned the forms, in contrast to a 51 per cent return by Columbia nurses. As a matter of fact, the total return of scorable questionnaires from State Park employees was 76 per cent as compared to 56 per cent from the Columbia division.

It might be anticipated that mental patients would find long questionnaire forms rather difficult and therefore would complete a relatively small percentage. However, of the 590 forms sent out, 433 scorable ones, or 73 per cent, were returned. This is a significantly higher percentage response than by staff. This result probably was due to the facts that patients generally have learned to comply with staff requests and also were supervised to some extent. If the forms not completed by patients are classified in terms of the reason for their not being filled out, it appears that 24 subjects couldn't read, 68 refused, and 62 were incapable because of their illness. Seventy-six per cent were completed by white patients, 70 per cent by Negro patients; 74 per cent by all female (regardless of race), 73 per cent by all males; and 82 per cent by open ward patients versus 66 per cent by closed ward patients. The latter proportions are significantly different and no doubt reflect the poorer adjustment of closed ward patients.

True-False Items. The major finding of that portion of the survey directed toward discovering the attitudes of staff and patients toward a chaplaincy program is that all groups expressed a liberal, accepting point of view toward chaplaincy's continued growth and development. However, it must be noted that about one-third of the subjects did not fill out the forms. This may have been due to indifference, negativism, or suspiciousness, in addition to inability to read; therefore, there is a distinct possibility that the questionnaires returned may be biased in a favorable direction for chaplaincy (i.e., mostly interested and cooperative subjects took the trouble to fill them out).

Although no striking differences in attitude were noted among the different classes of employees, it is interesting that nurses expressed the least favorable views toward chaplaincy, aides the most favorable attitudes, with physicians and medical auxiliary obtaining intermediate scores. As nurses and aides are the staff members who spend all their time on their wards, it is interesting that they have somewhat different attitudes toward chaplaincy. This may be due to the fact that nurses feel responsible for maintaining the ward routine and chaplains' interactions with patients are perceived as disturbing.

Negro patients expressed somewhat less favorable attitudes toward chaplaincy than white patients, possibly because they have less understanding of the significance of chaplaincy programs, but the difference was not striking. Female patients on closed wards and male patients on open wards are less favorably disposed toward an increase in religious activities than other types of patients, but there seems to be no obvious explanation of this finding.

Two items were included in the scale in order to determine what relationships obtained between personal involvement in religion and a tendency to urge patients to become involved in religious activities *and* general attitudes toward the chaplaincy program. It was suggested that religious individuals might display a more positive attitude toward chaplaincy than non-religious persons. This hypothesis was confirmed. No specific prediction was made for the other item, though it was believed that most subjects would indicate approval due to the positive valence attached to "going to church" in the Southern sub-culture. Actually, this halo effect was so overwhelming that the item was completely non-discriminatory; that is, 116 out of 127 staff members agreed very much or pretty much that patients should be encouraged to attend Sunday services as compared to one lone subject who disagreed very much or pretty much.

Analysis of the responses to the "I am a very religious person" item in terms of professional status was also done. If one omits medical auxiliary personnel from the analysis on the grounds that this group is very heterogeneous, the findings are as follows: Strongly agree (+2, +3)—aides 62 per cent, nurses 31 per cent, and physicians 15 per cent; Indifferent (+1, 0, —1)—aides 30 per cent, nurses 58 per cent, and physicians 75 per cent; and Strongly disagree (—2, —3)—aides 8 per cent, nurses 11 per cent, and physicians 10 per cent. Thus, it is clear that religious involvement varies with professional status—the higher the status, the less the involvement, and vice-versa. Actually, though our data do not permit the analysis, a key factor may be educational level. Median education for the aides is eighth grade, for the nurses high school, and for the doctors college, not counting professional training.

Multiple-Choice Items. All employee groups felt that chaplains were mainly counselors, although this view varied in terms of professional level and educational background. About 64 per cent of the physicians and medical auxiliary, 38 per cent of the nurses, and 44 per cent of the aides described chaplains as primarily counselors. The second most popular designation was "preacher" which was used by 25-30 per cent of each group. Very few staff members believed that chaplains are principally concerned with evangelism, administration, or teaching.

The perception of chaplains as primarily counselors was not shared by patients. Two-thirds of the Negro patients and 52 per cent of the white patients viewed chaplains as preachers. Only 9 per cent of the Negro patients perceived chaplains as counselors. These differences from staff perceptions are no doubt related to socio-economic and cultural differences between the patient and staff groups. But whatever the precise reasons for this discrepancy, it is clear that patients and staff will have quite different expectations concerning the services chaplains have to offer.

Almost two-thirds of the physicians and medical auxiliary personnel felt that "all concerned" (i.e., a team approach) should decide on a

patient's participation in religious activities, whereas only 44 per cent of the nurses and aides agreed with that point of view. On the other hand, 31 per cent of the aides felt that they or the nurse alone should make the decision, while only 6 per cent of the physicians and medical auxiliary personnel agreed with that choice. Very few of any group thought the chaplain should make the decision with regard to patient participation in religious activities.

There was a marked difference between staff-patient opinions and between white and Negro patients' opinions. White patients, interestingly enough, feel that *they* should make the decision. Very few believe that the doctor, nurse, aide, or chaplain should decide this for them, although about 25 per cent feel that "all concerned" should decide this issue. This difference from staff opinion is an obvious source of conflict.

The Negro patients, on the other hand, feel that their nurse, aide, doctor, or chaplain should make this decision for them. Only 9 per cent of all these patients believed that everyone should get together to talk about it. This finding implies that few conflicts are likely to arise in handling religious decisions with Negro patients, but also suggests that staff may eventually become disturbed over these patients' compliance and passivity.

Responses to the other multiple-choice items may be summarized as follows: (*a*) patients and staff agreed that chaplains should visit all newly admitted patients; (*b*) patients and staff disagreed over what patients derive most benefit from—staff feeling that individual visits were most valuable and patients stating that they get most out of Sunday services; and (*c*) patients and staff agreed that Sunday services were at the "wrong" time and difficult to understand.

Opened-Ended Items. Many subjects, both patients and staff, omitted these items, apparently being unwilling to commit themselves in this type of unstructured situation. Those who answered agreed almost unanimously on what would improve chaplaincy (i.e., more chaplains) and what chaplains did best (i.e., counseling patients and families and preaching). However, it was very difficult to capture the essence of the *criticisms* made of the current program. Some frequently made complaints were that chaplains: (*a*) rush through the wards, (*b*) show undue interest in selected cases (i.e., have pets), (*c*) come to the ward at the "wrong" time, (*d*) use formal worship services, (*e*) use hard-to-understand language, and (*f*) act "professional" instead of warm and friendly.

Examples of positive and negative reactions to the incomplete sentence "I wish the chaplains would quit . . ." may communicate the tone or flavor of the individual responses: (*a*) "no never to quit for that is our spiritual food and we gain spiritual strength through the church. Thanks God for the services" (from a Negro patient) and (*b*) "work at the State Hospital and get him a church of his own" (from a psychiatric aide in the Columbia

division). An unusually negativistic response to the stem—"chaplains are best at" . . . was given by the same aide: "causing confusion and meddling into ward affairs, then remaining aloft as the untouchable."

Summary and Conclusions

The main purpose of this investigation was to discover the attitudes of patients and staff toward a mental hospital chaplaincy program. Completed questionnaires were received from 135 employees and 433 patients out of the 202 employees and 590 patients to whom they were sent. Although some individuals indicated disapproval, there was an overwhelming vote of confidence in the current chaplaincy program by staff and patients. More religious persons expressed significantly greater approval of the program than individuals who deny religious involvement. Also, religious involvement was shown to be inversely related to professional status.

Another aspect of our inquiry was to determine what functions and activities of chaplains were perceived as most effective and/or valuable to the setting. Staff felt, in general, that chaplains were mainly counselors, but patients viewed them primarily as preachers. There was agreement that counseling and preaching are what chaplains do best. Teaching, administration, and evangelistic activities were not considered to be important aspects of a chaplain's role.

Many differences of opinion were expressed on the question of who should decide on patient participation in religious activities. Doctors and medical auxiliary felt that the team was responsible, aides felt that they or the nurses should make the decision, white patients felt that it was up to them to get involved or stay out of such activities, and Negro patients indicated that they would like the doctor, nurse, aide, or chaplain to decide for them.

Almost all respondents indicated that more chaplains are what is needed to improve chaplaincy services. Criticisms of the program are, however, almost as varied as the number responding.

The results show that colleagues and patients approve of chaplaincy in general, even though they often misunderstand the motives and goals of the chaplaincy program. Conflicting expectations of chaplains' functions demonstrate that much ground remains to be covered before personnel and patients are in accord with each other and mental hospital chaplains as to how chaplains can best operate to fill the spiritual needs of their mentally ill flock.

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A STUDY OF TERMINAL CANCER PATIENTS

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In reviewing our records of the pastoral care of twenty patients who died from cancer, we found a great difference in the way they reacted as death approached: Some moved positively toward acceptance of death, some moved negatively toward denial. The proportions were 12 patients, or 60 per cent, toward acceptance, and 8 patients, or 40 per cent, toward denial.

The judgment of acceptance or denial was based on my over-all impression as I reviewed my notes and recollections as to what each patient had said, what non-verbal signs he had given, what I had learned from the chart and from doctors, nurses, members of the family, and outside pastors. In every case I found that I could discern at some point in the course of the illness a change in attitude or mood which seemed to mark the setting of the direction of movement toward acceptance or denial. Changes which seemed to mark the positive movement were such as these:

from fretful fear to serenity
from panic fear to confidence
from despair and self-pity to quietness
from dog-in-manger to graciousness
from depression to quiet warmth
from anxiety to composure and relief
from chip-on-shoulder to curious wonder
from flippancy to gentle humor
from bitterness to matter-of-fact-ness

The negative movement seemed to be marked by such changes as these:

from willingness to talk to hostility
from appropriate fear to forced cheerfulness
from frankness to fantasies of recovery
from quiet bravery to depression
from cooperation to sullen fretfulness
from iron-man front to whimpering complaint
from confidence in recovery to preoccupation with minor symptoms

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Paper delivered at the meeting of the Chaplains' Association of the American Protestant Hospital Association at Columbus, Ohio, February 18, 1960.

The limitation of the review to 20 cases was determined by the fact that that number was all that I had sufficient notes on to make an assured judgment as to the direction of the movement. These 20 cases all showed a clear-cut diagnosis of cancer and prognosis of death either at the time of the patient's admission or soon thereafter, close contact by the chaplain through the whole terminal course, and adequate notes.

Twelve of the patients moved toward acceptance, 8 toward denial. Could I find any significant factors involved in the movement one way or the other?—any clues that might tell me what to expect in other terminal cancer patients? I tabulated the data under many headings, and came out with this description of the patients and their pastoral care:

All of the 20 were Protestant.

17 were private or semi-private patients, indicating comfortable economic status and implying good education and social backgrounds; 3 were ward patients.

18 were white; 2 were Negro.

Ages ranged from 29 to 83, with the main cluster from 46 to 65 (12 patients), and with an average of 53.

13 were women; 7 were men.

As to marial status:

8 were married.
7 were single.
3 were separated or divorced.
2 were widowed.

Their stay in hospital ranged from 28 to 288 days, with the main cluster from 63 to 123 days (11 patients), and with an average of 87 days.

Location of primary cancer:

14 cases in internal organs
3 cases in blood or bone
2 cases in the brain
1 case in the jaw

14 had to undergo surgery, 6 did not.

Chaplain's first contact:

7 on patient's own request
8 on referral from staff, family, or outside pastor
5 on rounds

Number of visits by the chaplain ranged from 7 to 40, with the main cluster from 10 to 24 (14 cases), and the average at 18.

Chaplain's total time with the patient ranged from 1 hour to 7½ hours, with the main cluster from 2 to 4 hours (11 cases), and the average at 3½ hours.

15 patients had members of family in attendance, 5 did not.

12 patients were active church members; 8 were inactive or non-members.

9 patients had an outside pastor in contact, 11 did not.

7 patients attended Chapel service at some time during their stay, 13 did not.

Doctrinal position:

2 were fundamentalist
10 were conservative
6 were liberal
2 were agnostic

Chaplain's ministrations:

17 patients entered into a counseling relationship with the chaplain.
16 asked for prayer.
14 asked for literature or reading of scripture.
5 asked for Holy Communion.

10 patients had been told the diagnosis by the doctor at the time of the chaplains's first contact; 10 had not been told.

14 patients at some point in their contact with the chaplain acknowledged that they had cancer; 6 either avoided or denied.

13 patients acknowledged or implied that they were going to die, or discussed the possibility of death; 7 either avoided or denied.

Direction of movement toward acceptance or denial became set:

12 times in connection with surgery
5 times in connection with diagnosis without surgery
3 times at end of long period of decline

2 patients indicated that they knew when they were about to die; 18 were either comatos or sedated into insensibility for days before the end.

When we started to analyze these factors, we found that some of them were simply peculiar to our selection of cases. The patients were Protestant because, since I am Protestant Chaplain, they are the ones I see in pastoral care. They were predominantly private or semi-private because, in our particular division of responsibility for areas of the hospital, they are the ones I commonly see. They were predominantly white because most of our private and semi-private patients are white. My first contact with them came mainly on request or referral because that is the way most of our contacts are made; we do not routinely see every patient on a rounds basis. These factors, therefore, could be ruled out as influencing positive or negative movement in our sample.

We then went to work on the other factors to see if any significant relationships could be established. Here I had the help of the Associate Chaplain in Research, who has a good command of statistical method. We used Chi-square and the Yates Correction for small samples, at a 5-per-cent

or better level of confidence. That is, we considered as probably significant only those relationships which showed a 5-per-cent or smaller probability that they were due to chance. On this basis most of the factors washed out. We could find no significant relationship between the patient's over-all movement and:

Age
Marital status
Length of stay
Location of primary cancer
Whether or not surgery was performed
Frequency of visits by the chaplain
Total time spent with the patient
Church status
Contact with outside pastor
Chapel attendance
Fact that doctor had told patient the diagnosis
Time in illness when direction of movement became set

We found two tendencies toward relationship, both of which fell short of significance on a 5-per-cent level of confidence, but proved out at around the 11-per-cent level:

Women tended to show positive movement toward acceptance of death, and men negative movement toward denial.

Patients with family in attendance tended toward over-all negative movement, those without family in attendance toward over-all positive movement.

We would have to find the same results in a considerably larger group before we could say they were significant at the 5-per-cent level.

We also tested many combinations of factors to see if there were significant relationships between them without reference to the over-all movement. No more than a chance relationship was found between the following factors:

Frequency of prayer and age
Frequency of prayer and sex
Frequency of prayer and surgery
Church status and chapel attendance
Church status and requests for chaplain
Church status and counseling relationships
Church status and acknowledgment of cancer, and of death
Church status and disclosure of anxiety before diagnosis

A few tendencies appeared which, if found in a larger number of cases, might prove to be significant:

The chaplain's first contact with church people tended to come before the patient knew the diagnosis, or before the threat of cancer

had become explicit, while with non-church people the contact came after the patient knew, or after the threat had become explicit.

Church people tended more than non-church to acknowledge the possibility of death before they knew the diagnosis.

Doctrinal conservatives tended more often than liberals to ask for prayer.

Both conservatives and liberals tended to ask for prayer more often than did fundamentalists.

These relationships are all, on the basis of 20 cases, quite inconclusive, but they do suggest lines for further investigation.

What, then, did we find of significance? Five things:

1. *Church people,* more than non-church people, in a significant degree asked for *prayer.*
2. Patients who *acknowledged their cancer* showed in a significant degree an over-all *positive movement* toward acceptance of death; and those who did not acknowledge their cancer showed an over-all negative movement toward denial.
3. Patients who *acknowledged* the probability or possibility of *death* showed in a significant degree an over-all *positive movement* toward acceptance of death; and those who did not acknowledge it showed an over-all movement toward denial.
4. Patients who had *counseling and prayer* showed in a significant degree an over-all *positive movement* toward acceptance of death; and those who did not have counseling and prayer an over-all negative movement toward denial.
5. Patients who in doctrine were *conservative or liberal* together showed in a significant degree an over-all *positive movement* toward acceptance of death; and those at the doctrinal extremes, fundamentalist or agnostic, together showed an over-all negative movement toward denial.

The first statement, about church people and prayer, is hardly surprising in that it confirms what I suppose most of us would say was perfectly obvious. However, it does tend to cast some doubt on the popular notion that in time of trouble everybody prays—that "there are no atheists in fox-holes."

In regard to the second and third statements, about acknowledgment of cancer and death, here is evidence clearly confirming what we all devoutly hope is true—that if a patient can talk about something he fears, he is better able to meet it. And that turns out to be true, not only for the passing dangers of life, but for the fearsome disease of cancer and the threat of death, the last great enemy of all.

In regard to the fourth statement, about counseling and prayer, notice the "and." The two were in conjunction. I had no appreciable number of

cases on which I had adequate notes in which only counseling or only prayer was a factor. So I cannot, on the basis of this review, say anything about the relationship of counseling by itself, or of prayer by itself, to the direction of the over-all movement. The results shown here depend upon "the old one-two."

And in regard to the fifth statement, about doctrinal position, it should be noted that the number of fundamentalists and agnostics was very small. While the equation we used in testing is supposed to allow for this, I still feel a little uneasy about it, and would like to see it tested in a larger group. It would, however, seem to be clear that conservatives and liberals are not quite at as great a disadvantage as the fundamentalists allege, if the way they move toward death is any index.

One other matter should be noticed. In the 13 cases where the patient spoke of death to the chaplain, not a single one indicated that he had mentioned the subject to the doctor, or the doctor to him. I suspect that here is an area of human experience which is felt by both doctor and patient to be so threatening to the doctor-patient relationship as to tend to inhibit all reference to it. But it is revealing that the patients felt free to speak of death to the chaplain. Here is an area of the patient's experience in which he feels that we belong in a way that no one else appears to.

In the whole series of cases one thing was very apparent—an absence of any lively sense of the hereafter, even among the most devout. The only one of the 20 patients who had anything to say about the after-life, and with open composure gave his interpretation of it, was one who called himself an agnostic and had most of his life been in rebellion against the orthodox teaching of his youth. He, by the way, finally made his peace and asked for Holy Communion.

Only two of the 20 patients were really permitted to *meet* death. Among the other 18, in several cases the brain was affected for days before the heart gave out, and the patient lingered in a coma; and several had such terrible pain that extremely heavy sedation had to be given; but the others were drugged into lethargy as the end drew near, well before they had lost their wits, so that they had no opportunity to know that they were going. Doctors avoided the subject of death, maintained with the patients the fiction that they were going to get better, did not let them knowingly meet the last great experience of life. Why?—could it be that they, along with most of the rest of us in our world today, have lost their sense of the hereafter, and are afraid?

I do know this: that the two patients who were permitted to know when they were about to die met death bravely, not quite with banners flying, but with serenity and dignity, as befits a child of God. And I am sure that some of the others among the 12 who showed over-all positive movement toward acceptance would have done the same, had they been allowed to do so. But I cannot prove it statistically!

RELIGION AND THE ACUTE PSYCHOTIC

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Experience at the Cleveland Psychiatric Institute, an intensive treatment and research institution, has revealed a type of patient which is of special interest to both the psychiatrist and the chaplain. Usually the patient is an acute case who shows an intense religious coloring to his illness. Within a few weeks the illness subsides and the patient may be of assistance in clarifying what happened to him. The observations to be presented in this paper were made at a weekly seminar held jointly with the chaplains.[1]

The seminar is attended more or less regularly by some twenty to thirty people, including three or four new residents, one or two staff psychiatrists, and a sprinkling of workers from the Social Service, Occupational Therapy, and Nursing Departments. We have seen thirty-five patients, not enough to use for statistical deductions of any kind, but enough to stimulate our thinking and to provide ideas for future explorations.

There was surprise on the part of some of the personnel and staff at the Psychiatric Institute when I first revealed my interest in the religious aspects of mental illness. Here, as in other psychiatric settings, strong religious interest tended to be equated with mental aberration. However, after a year of the weekly seminars, there has come to be a good deal of appreciation of the complexity of the field of religion and the number of useful contributions that it can make, at least to the evaluation and prognosis of the patients' illnesses. From the outset, it could be seen that the highly religious patients were puzzling and interesting cases and not the usual paranoid schizophrenics. Then, as we kept producing new patients week after week for this seminar, the sheer quantity of these cases was impressed on the consciousness of our staff. We could not continue to be indifferent about so large a group of patients. Also, some of the most peculiar of the religious patients left the hospital, obviously were not behaving in an ill fashion, and still sounded very religious.

It would be amusing, if it were not tragic, to observe the almost complete inability of mental health personnel to evaluate the patient who introduces religious material in the interview. It is almost as if this material were considered by definition to be psychotic, regardless of the patient's behavior and the presence or absence of other symptoms. Only by bringing

Adapted from a paper read before the Association of Mental Hospital Chaplains, Atlantic City, New Jersey, May 1960.

[1]Fathers D. Lasky and K. Bowler, Rabbi W. Seligman, and the Rev. F. Hutchings.

those who had had a conversion experience back to the hospital repeatedly for interview and by presenting such patients during the same conference at which really helpless psychotics were present could we get across the idea that religious experience is not in itself necessarily synonymous with psychosis. I think the key to the differentiation lies in the presence in the psychotic of real powerlessness for reasons mainly psychological, partially sociological and physical, which the patient must deny completely, while the converted patient carries on as well as he ever did and possibly better. Certain grandiose-sounding statements that he makes can be recognized as typical of religious persons provided one is familiar with the literature. He also will make many more statements of humility than will the psychotic.

Undeniably psychotic was a 44-year-old, unemployed Negro male who was admitted to our hospital after he had undressed on the steps of a police station in response, he said, to a command of God. He had left his family in the South twenty years before and had come to Cleveland seeking employment. Poorly educated and somewhat shy, unsuccessful in obtaining steady work and finally forced to sleep in parked automobiles, he was the picture of a complete failure in life. On the ward he was uncooperative, seclusive and idle, and full of ridiculous ideas, claiming that he was shot five times in the heart, but was resurrected each time. He was not at all sorry about his failures; after all, God is all-powerful and one cannot tell his purposes. It was clear that his religious ideas gave him excuses but no real power.

On the other hand, we interviewed a 33-year-old Negro nurse who, following a period of mounting stress at home, had for the first time in her life felt really helpless. She went to bed feeling disconsolate three nights before admission to our hospital but woke up at 3:00 A.M. with the conviction that everything was all right, her problem was in God's hands. Elated and euphoric, she thought, "I didn't choose Him, He chose me." For the first time she had a deep interest in the Bible and the next day went to church. A day later, following admission to our hospital, she seemed aggressive and over-active, and began to hold conferences with our patients, trying to help them. She told us, "I am afraid of this new power, but I seem to have found my life's work." She took to reading William James and was particularly interested in James' statement that George Fox, though converted, was not insane. She claimed to be full of love, saying, "My God loves, He will forgive anything. I cannot hate anyone. God is Eternal Love. I am one of his chosen ones." She *knew* that she had had an experience given to her by an outside power and didn't have to prove it. However, she admitted fatigue and nervousness during the first few days after coming to the hospital and further stated that maybe she was insane for six hours or so. Shortly after her initial powerful experience she felt a battle inside her between the forces of good and evil. She does not plan to start her own church, but will join one and get baptized,

feeling that though she has religious power she does not have the strength to initiate her own religion.

The sequence of her conversion, according to the patient, was as follows: Her sister had been dismissed from nursing training unjustly and there was nothing either could do about it. Feeling that she had met a situation that could not be handled alone, our patient prayed to any unknown god, although she did not really believe, and finally had her strange experience. When interviewed about five weeks after admission, the patient appeared over-talkative, somewhat too positive, too sure that she had been chosen. Many of the doctors were of the opinion that she was still psychotic and would soon relapse.

The patient was brought back for interview two months later. This time she was quite asymptomatic, displayed a good sense of humor and no push of speech, was working and taking care of her family, and had joined the Baptist Church. She told us how she had been angry over the episode involving her sister, could not blow off steam, and had become confused, tired, and nervous. Now she did not bear a grudge and would let her sister fight her own battles. However, she was still very religious and quite self-critical and kept trying to do something about her excessively selfish and introverted personality.

To be sure, while this woman appears to have had a fruitful conversion experience, even she did have some overtones of mental illness which might, at least for a few days at the onset of the sudden conversion, have required the skills of both psychiatrist and religious worker to distinguish positive and negative aspects of the condition. In many of the patients who reach the hospital there is this apparent mingling of religious and psychopathological material. The unusual experience, even if ultimately positive, seems at first to overwhelm the personality, requiring a period of rest. In some cases it appears that the same emotions that lead to a resolution through positive religious experience may at the same time in the same person resolve themselves through a concomitant psychosis so that both conditions are present. We have also seen partial conversions where the patient has remained fanatic. Hostility has not been fully resolved or converted into love, but expresses itself through the appearance of exaggerated love and exaggerated single-mindedness. This rabid condition almost invariably nullifies the good the patient is apparently trying to accomplish, leading to a vicious circle and increasing bitterness which is expressed in ever mounting religious preoccupation. On the basis of my observations, I cannot agree with Saltzman[2] in characterizing all emotional conversions as regressive. Within the category of these sudden emotional occurrences, there is a continuum from a benign and fruitful outcome to a severe fanaticism in which it appears that the patient is motivated by as much hostility as he had to start with, only now it is covered by the mantle

[2]Leon Salzman, "The Psychology of Regressive Religious Conversion," *Journal of Pastoral Care,* VIII (Summer 1954), 61-75.

of religion. One factor that is well worth keeping in mind is that some patients may be suffering from a lack of guidance, not misdirected hostility. They may need help in understanding Biblical passages and in grasping the import of their new religious experience. The motivations and crises leading up to the change in the person are, I think, important to know, but the value of the conversion must be judged by its effects.

In the seminars a number of quite varied religious experiences have been reported to us which differ from conversions in that they do not appear to have changed the patient's moral character. The crisis was there all right, and the hostility and helplessness. To illustrate, we saw a 21-year-old, white Protestant man whose wife had left him. He displayed a picture of mental blocking, particularly when his wife was mentioned, and depression and remorse for his mistreatment of her. Shortly before admission he had a visual hallucination in which he saw the Light of God and saw himself in the Light. The Light represented to him the meaning of life—namely, that people can be happy together, specifically "my wife and I." The experience thus is precipitated by hostility and guilt, but mixed with a wish—in this case to get back together with his wife. This formula can be exemplified by half a dozen of our cases, a few of which will be mentioned. One woman, dissatisfied with her marriage, had a feeling of power that would enable her to cast the devil out of her husband. The same patient, a young Negro girl, also had had a fugue state during which she looked for pass words to join the Masons. Her dislike of being an outsider thus led to a bizarre hysterical experience which ran concurrently with the religious experience just mentioned. We saw a 33-year-old, white, Baptist, married woman who was terribly frustrated in her relations with her husband and with her father, whose religious experience was characterized by the feeling that Christ was in bed with her and in her body. There was a 47-year-old, Catholic, married man under severe financial pressure whose emotions boiled over because of what he felt to be an unjust debt. He suddenly felt that he was in possession of special powers and had a strong urge to begin a Lourdes Clinic where people would be fair and decent. In these cases there is an involuntary transmutation of hostility largely into religious feelings and ideation which does help in that it restrains the patient from hurting anyone physically.

In other cases the patients voluntarily turn to religion for support. The help they get seems specific to their needs. They pray for protection, for peace of mind, for relief from burden and confusion and despondency. One patient reported that she healed herself by praying and fasting, and it appeared as if she had been quite successful. To be sure, assistance gained this way is often not sufficient and the patient goes into mental illness. One patient was of special interest. Her mother was a Roman Catholic, her father Greek Orthodox, and her husband Protestant. When this young married woman turned to the Bible for support during a time of strain, her confusion became compounded because she did not know which Bible

to turn to. Maybe there are some implications for child-rearing in this case.

I would like to cite one case in which religion did nothing to divert hostility, but gave it a rationale. This was a 29-year-old, white, divorced woman who reported little religious interest prior to her current situation. She had been divorced from her husband the year previously, but her recriminations and desire for revenge had continued. As she was driving from the home of a boy friend, a feeling came over her that she had to do the will of God; then God told her to hit another car, and she did. The result was that she killed a pregnant woman driving in another lane. Such cases are not common, although all of you have read about them because they are sensational. I doubt that religion is to blame. Our acute case material shows that, in the vast majority of instances, extreme hostility is successfully warded off by the patient's defenses, not the least of which are religious defenses.

Finally and inevitably we must include a word about unreligious patients. These comprised large percentages in the series of Oates[3] and Southard.[4] The conclusion of Oates that mental illness is the end result of a lack of wholesome moral education cannot yet be considered valid. After all, many of the religious were severely mentally ill too, and presumably many of the reasonably healthy people outside institutions are not religious. During the past few weeks we have brought before our seminars two obviously unreligious men and we shall continue to consider this type of case in a search for answers to certain important questions which our previous experience with the more religious makes it possible for us to ask. Do the seemingly unreligious really have a religion, and where is it? Must it be present by some principle of conversation of energy like that in psychoanalytic theory according to which libido dammed in one place reveals itself in another? Can we devise a suitable spiritual inventory analogous to the mental status examination used by psychiatrists to determine the presence and type of mental derangement? Even with just our two cases we have found that the spiritual examination has brought into focus many facets of the personality not reached by the usual psychiatric approach and, furthermore, that it takes longer to carry out. It is, by the way, unusually tiring to the patient. We seek the patient's own evaluation of his living patterns and habits and his concern for his own ethnic or racial group, his goals and ideals, and attitudes toward solitude, people in general, religion, himself, and much more. We hope first to be inclusive, then to narrow down to what is crucial and indispensable. It is already apparent that this line of questioning brings us to a close knowledge of our patient as a person and has a peculiarly sobering effect on him. After we had interviewed our most sociopathic patient this way, he appeared very thoughtful for a few days and told his nurse he would not escape again

[3]Wayne Oates, "The Role of Religion in the Psychoses," *Pastoral Psychology,* VII (May 1950), 35.
[4]Samuel Southard, "Religious Concern in the Psychoses," *Journal of Pastoral Care,* X (Winter 1956), 226.

but stay for therapy. He was surprised, he said, that the questions were of such a type that he could not lie about himself. A fuller presentation of the patterns within the spiritual dimension of these characters will be saved for another time since the possibilities for personality and symptom evaluation, treatment, and mental hygiene are evidently vast.

Summary

Differentiation between real religious phenomena and psychopathology is important for evaluation and prognosis of psychiatric illness but remains a difficult and mystifying task for those mental health personnel and even those members of the clergy who are unfamiliar with religious psychology. The psychotic differs from the converted patient in his real powerlessness coupled with denial of this and furthermore displays bizarre behavior which is not consistent with descriptions of typical conversions. Many religious experiences do not lead to changes in moral character. These experiences are involuntary and in susceptible persons are end results of combinations of hostility, inwardly or outwardly directed, and a wish. Many patients are able to turn voluntarily and with some success to religion to meet a variety of needs. In others, hostility is not diverted from dangerous expression, but is given a rationale by religious ideation. Spiritual examination offers exciting new vistas for personality study and treatment, especially after it has been refined and we have gained experience in its use.

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On the Introduction of Clinical Pastoral Training in England

The introduction of clinical pastoral training in England by the Rev. Norman Autton crystallizes the many evidences of interest on the part of Englishmen during the past several years. Englishmen will not only gain the specific benefits which Autton and his students derived from clinical pastoral education. They will also bring to the clinical understanding of theology a new and fresh contribution of their own. Their finely developed sense of history, their carefully disciplined appreciation of the centrality of worship, and their unmistakable rootage in the life of the Church all stand out in this article describing the training programs. The intrinsic identities of the Christian faith will never be ignored or made peripheral in the clinical pastoral education conducted by the English. The point at which American approaches began—with the problems of sin and salvation and man's struggle for redemption—and to which, after much casting about, is returning is the point of departure and commencement for this program. These men reflect a clear image of themselves as men of prayer, representatives of God, and instruments of worship in the whole process of education.

It is heartening indeed to see what many an American chaplain would desire: the active initiative and interest of the principals of the theological colleges. Those of us who have been in correspondence with these principals find a refreshing interest and encouragement concerning clinical pastoral education on their part. The carefully detailed article by Paul Johnson, "Pastoral Psychology in Scotland and England," in *Pastoral Psychology,* October, 1960, reflects this same concern and suggests that Chaplain Autton shall not be without many colleagues in the training of theological students in clinical settings. He already has others in his company.

One of the wholesome aspects of this development of clinical training in Britain is the possibility of exchange students. With the cost of transportation becoming less and less expensive between our two countries, this

seems to be much more easily within reach than we would have dared imagine even a few years ago. The resulting dialogue will relieve us of much of our provincialism and renew again in us the knowledge that the suffering human being in need of the cup of cold water in Christ's name, like Christ, "knows no north or south, east or west."

W. E. O.

COMMUNICATIONS

The Introduction of Clinical Pastoral Training in England

The first clinical pastoral training course to be undertaken in England recently took place at the Deva Hospital in Chester, a psychiatric hospital of approximately two thousand patients. Since 1957 almost one hundred theological students and clergy had received training from the Chaplain in clinical orientation in short introductory courses of from one week to ten days' duration. It should be explained that these courses were limited to very brief periods as most of the theological colleges have four terms a year, and the average stay of the student in college is two years. This leaves very little time for long and intensive courses outside the present theological curricula. As a result of the experience so gained, and after a three months' study of clinical training in the United States (April-July 1959), the Chaplain was able to organize the first clinical pastoral training course at the above hospital from June 20-July 29, 1960 (six weeks).

Within a few weeks of the news being circulated of this pioneering project both in the Church press and in theological colleges, almost thirty applications were received, and many principals were prepared to release their students in term-time to allow them to attend. As the writer was working very largely on his own, and from his study of clinical training had observed how important is personal supervision, it was decided to limit the number of students attending the course to six. To help in the final selection, a questionnaire was sent to each applicant asking him, inter alia, to state fully his reasons for applying. It may interest the reader to learn of some of the reasons stated:

> Since theological colleges do not emphasize pastoral psychology, I feel that a course of this nature would be of considerable importance for my future ministry.
>
> The deeper insight into human life, which this course could not fail to give, would be of infinite value in dealing not only with the mentally and physically sick, but also with the everyday worries and anxieties which confront all of us.
>
> I wish to learn more about the human personality and at the same time acquire a deeper understanding of myself as a person.
>
> An American friend of mine has been tremendously impressed by the effect of similar courses in the United States.
>
> This was exactly the sort of course which I was hoping for a long time could be arranged by the Church.

In the selection of candidates the Chaplain gave priority to those who were in their final year of theological training, for such students would have had sufficient theological background against which to place the varied

problems they would meet in such a course. Three of the successful students were personally known to the Chaplain through his visits to their respective colleges. (One of the three had attended a short introductory course at the Hospital the previous year.) The other three students were highly recommended by their principals. It was evident that among the applicants were a few who were looking for help in their own emotional lives, and had great personal difficulties. It was not thought prudent to include these in a pioneering venture of this sort. Among the six was one Deacon who had been ordained just one week before the commencement of the course and had been granted special permission by his Diocesan Bishop and Rector to spend his first six weeks of ministry in training at the Hospital. One student had worked as an "orderly" in another mental hospital, and another as a "theatre attendant" in a general hospital, during previous vacations. Both felt a vocation for mental hospital chaplaincy ministry. The others had had various stages of hospital experience, but to the majority the mental hospital was quite an unknown field of study.

The Hospital Management Committee had fully sanctioned the course, and through their help and cooperation the six students were provided with accommodation in the Hospital throughout the whole six weeks of the course.

Many of the important features of clinical training which the Chaplain had been able to observe in America were incorporated in the program, but obviously certain adaptations had to be made to meet hospital routine in this country. The main outline was as follows:

1st Week—Introductory lectures and orientation
2/3rd Weeks—Orderly duties on assigned wards—7 A.M.-4 P.M. (One evening a week—11 A.M.- 8 P.M.)
4/5th Weeks—Pastoral visitations on assigned wards; lectures; role-playing; tape-recordings; case-discussion
6th Week—Seminars; summing up and evaluation

As this was the first course, it was thought wise to arrange a rather highly scheduled program. One sermon was preached by each of the students in the Hospital Chapel on the successive Sundays of the course, and they participated in ward services and ward prayers, etc. A daily Holy Communion Service was held in the Chapel each morning at 8 A.M., and the Chapel was open for prayer, meditation, and intercession. A book-list had been forwarded to the students before the course began, and reading periods were arranged in the program.[1] Reports of impressions gained and work accomplished were written up each week by the students, and they were

[1]Some of the required reading consisted of the following: *Christian Essays in Psychiatry,* Ed. Mairet, S.C.M. Press; *Psychiatry Today,* Stafford Clark, Penguin Series; *To Define True Madness,* Yellowlees, Penguin Series; *The Church's Ministry of Healing,* Purcell Fox, Longmans; *A Priest's Work in Hospital,* Ed. Cox, S.P.C.K.; *Psychology, Religion and Healing,* Weatherhead, H. & S.; *Psychology and Morals,* Hadfield, Methuen; *Psychology for Ministers and Social Workers,* Guntrip, Independent Press.

also encouraged to describe their pastoral interviews with patients as verbatim as possible.[2]

First Week: Introductory Lectures and Orientation

This first week was meant to give the student an introduction to the Hospital and its routine, and the types of mental disorder he would be encountering, together with the various types of therapy used. It was planned with the object of providing the student with a logical progression in the understanding of the various problems of the mentally ill, and to make evident the role of the priest in dealing with these. It was also considered beneficial to relate much of the program to the links between parish and community, for after ordination all the students would be in a parochial ministry.

The Lord Bishop of Chester welcomed the students on the opening of the course and lectured to them on "Ministering to the Sick." The Medical Superintendent gave two lectures at the beginning and the end of this first week on (1) "Varieties of Mental Disorder" and (2) "Varieties of Treatment of Mental Disorders." The Deputy Medical Superintendent outlined "Early Symptoms in Mental Disorder." On the first day, the Chaplain explained the main features of clinical pastoral training, and admission and discharge procedures were also made plain. The heads of the various departments all outlined their own roles and the students heard lectures on the work of the physiotherapist, occupational therapist, social worker, clinical psychologist, and the Hospital administrator.

During the opening days of the course, the students were conducted around the various wards and departments of the Hospital and introduced to staff members, etc.

Impressions. At this early stage of training it was to be expected that there should be some personal anxiety, and this was evident in some of the written reports. As Bruder suggests, "This may be due to the newness of the experience, or to the fact that he is uncomfortable about what this is going to tell him about himself . . . or he may be afraid of being attacked by patients, or it may be that for the first time he is expected to be more of himself than ever had been possible before . . ."[3] There were many questions asked, e.g., "How long should I spend in Ward—?" "What length reports do you require?" etc.[4]

Although there was apprehension beforehand at the length and intensity of the program, it was evident to one student that "six weeks is far too

[2]The method of writing up the material was outlined roughly as follows: *Observations* (appearance of patient, attitudes, etc.); *Interview* (keywords of interview and verbatim report); *Conclusion* (analysis of what took place, criticism of own responses, opportunities for positive steps).

[3]Ernest E. Bruder, "Some Theological Considerations in Clinical Pastoral Education," *Journal of Pastoral Care, VIII* (1954), No. 3, p. 141.

[4]Bruder, *op. cit.*, p. 138.

short a time in which to fit everything that would be of value." The "normality" of the patients impressed itself upon the students, e.g., "What struck me most was my inability to distinguish in many cases between staff and patients." Again, "One important lesson that I learned . . . was that the patients are individual human beings and not inanimate objects"; "Before this week I hadn't a clue about what a mental hospital was like." All students were impressed by the worship, both in the Hospital Chapel and the wards. "On Sunday I was overjoyed to worship with the patients. I was greatly helped and uplifted by the whole-heartedness of the worship . . . how wonderful the worship in the ward services was . . . I was very glad to know patients in their religious life; so very necessary after hearing so much about their psychological life . . . "

Second and Third Weeks: Orderly Duties on Assigned Wards

The next two weks were spent working as orderlies on the wards of the Hospital. This not only afforded the student a wonderful opportunity of getting to know the members of the staff, but also of observing the patient and understanding a little of his problems, fears, and anxieties. The students worked the normal orderly hours, with a change of shift one day a week (11 A.M.-8 P.M.) so that each might gain an insight into the evening routine of the ward. A daily note was kept of the work done and impressions gained.

Impressions. For one student there were two major results of this experience: (1) "One doesn't feel afraid to go on a ward to talk to patients now," and (2) "One has learnt to talk to patients, to know them, and to learn something of their illnesses." Another suggested that there should be regular pastoral visiting from theological colleges of the aged and the mentally ill to overcome fears, etc., and that courses such as the present one should be arranged to make some or all attain acquaintance with a far wider range of patients in a short time, and to learn more of the problems concerned with their care.

All the students found great spiritual help from the daily Eucharist. As one student put it, "To go out on to the wards as vessels of the Holy Sacrament is most helpful and strengthening." One student raised the question, "In talking to men who are deluded or hallucinated, I wonder how much one should accept their assumptions of reality. To understand them, it is important to listen, but does this mean acquiescing in falsity: if so, how much?"

Another student writes: "To sum up, this two weeks has been one of the most valuable in my whole life, and I thank God for the privilege given me." It is significant that this student worked on a ward whose patients were very severely mentally ill and demented.

Fourth and Fifth Weeks: Pastoral Visitations

Now that the students had become familiar with ward duties and routine and had come to know members of the Hospital staff, the next

period of training was spent in pastoral visits to assigned wards. A letter was sent by the Chaplain to each ward explaining the duties of the student and the significance of his presence on the ward, etc. It was emphasized strongly that the main objective of the student was to listen and learn. As far as was practicable each student was assigned a cross-section of the Hospital, e.g., Admission Ward, Disturbed Ward, Hospital Ward. It was also emphasized that at this stage of his training the student should not attempt to offer therapy, gather information or counsel, but to offer friendship and empathy.

Throughout these two weeks further lectures were arranged to afford the student a knowledgeable background on such subjects as "History and Modern Trends of Mental Nursing," "Alcoholics Anonymous," "The Doctor and the Priest," "Guilt, Suffering and Futility—Mutual Problems," "The Church and Mental Health," and "Pastoral Counseling." For the latter subject the group derived great value from listening to the tape-recording on "A Counselling Interview" (Dr. Clifton E. Kew).

Role-playing also played an important part in this stage of the course. The Chaplain role-played the "depressed patient," and the "guilt-ridden patient," and from the reports of the students much help was derived from this technique.

Impressions. The students were now developing the art of group discussion and were more and more integrated as a group. "That our opinions are valued is a tremendous incentive to serious thought about the Course," writes one. "I am so glad there has been humour in our meetings." For another student it meant "letting off steam!"

The role-playing brought home to the majority of the students the tendency to "talk too much." Many a student in his anxiety found himself delivering a "sermonette," or entering into theological discussions on suffering, etc.[5]

The nature of pastoral visiting prompted one student to confess that "ward visiting is as exhausting as orderly work, but I guess we would not have it otherwise!" "I find myself," writes another, "meditating on the fact that Christ died for all these men and women. With this in mind no situation seems awkward or anxious. If they can see the love of Christ in us, we shall have done what is required of us at present."

Sixth Week: Seminars; Summing up and Evaluation

The sixth and final week was spent almost entirely in seminars and group discussion. Among the subjects discussed were: "Preventive and After-Care of the Mentally Ill," "Worship and Preaching in the Mental

[5]C.f. Ernest E. Bruder, "Present Emphases and Future Trends in Clinical Training for Pastoral Counseling," *Pastoral Psychology,* April 1960: "He indulged himself in considerable moralization and 'good advice,' all of which was quite pertinent to what was being discussed but apparently was neither heard nor appropriately responded to by the patient."

Hospital Chapel," "Ministering to the Families of the Mentally Ill," and "The Value of Clinical Training" (one student responsible for opening this discussion produced 27 points appraising clinical training!).

During this final stage of training, the Lord Bishop of Lichfield, Chairman of the Hospital Chaplaincies' Council of Church Assembly (the official Body of the Hospital Chaplaincy Service in the Church of England), and Chairman of the Churches' Council of Healing, visited the course and lectured on "The Work of the Hospital Chaplain." Previous to his Consecration, the Lord Bishop had been a chaplain to a very large general hospital.

Final Impressions. The student was now encouraged to stress his relationships with the patients he had visited and the staff with whom he had worked, as well as his relationships with his fellow-students. He was also asked to state his own reaction to clinical training, and any insights he had gained into his own personality, together with a critical evaluation of the course as a whole.

The majority of the students expressed regret that the course was reaching its conclusion. "I keep on wanting to add to the program, without taking anything away," was how one student expressed himself. Another, who had been most apprehensive about the length of the program during the first week or so, confessed that "I realize now that six weeks is far too short a time." A third stated that "when I received the program I was terrified by the intensity of the course. Now I realize that the course was not too long but just too short! To me this has not been just another course, but an unique experience. It has been of tremendous importance in providing the opportunity of learning pastoral care and of great value for training in counseling."

There was also some apprehension about the emphasis throughout the course on the importance of writing reports, etc. This seemed a new discipline for many, and something which needs to be cultivated further in our theological education.

> I was rather alarmed to see the emphasis laid on the writing of reports . . . I thought I would find it very difficult, and indeed I have done. However, from doing them I derived a great deal of help, particularly in self-expression and also in some degree in self-understanding.
>
> The exercise of writing up our impressions after most days was extremely valuable, and makes me more observant than I would otherwise be.
>
> Writing reports on our activities has certainly made us think a little more about what we were doing.

The four primary objectives of the Institute of Pastoral Care and of the Council for Clinical Training had been outlined for the students at the commencement of the course, and in the evaluation of this pioneer course it is necessary to examine whether these were achieved to some degree.

1. "To enable the student to gain a fuller understanding of people . . ." In his final report every student stated how he had been helped to achieve this objective:

> Above all, it has taught me to deal with people, not patients, nor cases, but individuals.
>
> I have found a new level of love for people—depths of which formerly I thought I was incapable.
>
> I have been helped to understand people . . .

2. "To help the student discover more effective methods of ministering . . . and to intensify his awareness of the unique resources, responsibilities, and limitations of the clergy." That this was fulfilled is evident from the following quotations from reports:

> My future ministry cannot help but be affected by what I have seen and learned here.
>
> It has shown us how enormous is our responsibility as priests, pastors and ministers.
>
> I have come to realize even more the magnitude and gravity of the pastoral office, the necessity for a genuine love of people, of all sorts and conditions of men, and the importance of a sound theology.

It was here, too, that a little of the great art of listening was brought home to the student. This was a hard lesson to learn, and the tendency to "do something" or "say something" was strong. However, at the end of the course, the remark of one student seemed to sum up the attitude of the group: "I thought beforehand that I *had* learned to listen. Now I see how little I had learned!"[6]

3. "To help the student learn to work cooperatively with representatives of other professions . . ." In England, as a result of the recent Mental Health Act of 1959, more and more onus is being brought to bear on the local authorities and community in the whole field of mental health. The problem is becoming more and more "everybody's business." Throughout the course the students were led in close contact with representatives of the local authorities and social agencies in an endeavor to establish a strong liaison between them.

Throughout the past few years great efforts have been made to foster an active cooperation between Church and medicine. In lectures from and discussions with psychiatrists and physicians fundamentals of cooperation were able to be examined ("The Church's Ministry of Healing," "The Doctor and the Priest," "The Church and Mental Health," "Guilt, Futility and Suffering—Mutual Problems," and discussions of case-histories, etc.).

[6]C.f. Ernest E. Bruder, "Training and the Mental Hospital Chaplain," *Journal of Pastoral Care,* XI (1957), No. 3, p. 141; also "A Survey of Ten Years of Clinical Pastoral Training at Saint Elizabeths Hospital," *Journal of Pastoral Care,* X (1956), No. 2, p. 91.

4. "To further the knowledge of problems met in pastoral care by providing opportunities for relevant and promising research." It is to be hoped that such a course will open the field for more and more study and research in the whole field of pastoral care. Some of the students have already returned to their theological colleges and reported on the course, and are attempting to create further interest in the whole problem. "I can hardly cease applauding the whole concept of clinical training." writes one, "for the principles underlying it are both sound and constructive." "I would not have missed this for the world," writes another. Again, "What one hopes and prays for now is that these courses will spread so that a maximum number of priests within the Church are aware of the many sides to, and needs in, this particular work."

Finally, it was evident that such training, to be effective, must be reinforced by spiritual exercises. One's ministry to sick people is not only physically fatiguing, but also spiritually exacting. The daily worship together in the Hospital Chapel throughout the six weeks of the course proved of tremendous help to all. As one student expressed it: "The need to have a really firm rule of life, daily Offices, Eucharist and meditation, whereby one's spiritual reserves may be replenished, has been made abundantly clear."

The writer would like to take this oportunity of expressing his gratitude and appreciation to those who made his study in the United States possible and arranged his itinerary, to the Chaplains of the various hospitals visited, as well as the members of the theological faculties whom it was his good fortune to meet. All so freely gave of both their knowledge and experience in this field of training. Perhaps it is evident from what has been outlined above that it has proved of the maximum help to both student and Chaplain.

THE REV. NORMAN AUTTON

Deva Hospital
Chester, England

The Fall Conference of the Institute of Pastoral Care (1960)

The Second Annual Conference of the Institute of Pastoral Care for Chaplain Supervisors was held October 24-26 at the Congregational Center in Framingham, Massachusetts. The Conference was attended by seventy-nine supervisors and potential supervisors.

On the afternoon of October 24 the Board of Governors held its regular meeting at the Conference Center so that the supervisors might attend and become acquainted with the members of the Board. At this meeting the following were accredited as Acting Chaplain Supervisors and Chaplain Supervisors:

Acting Chaplain Supervisors—William F. Adix, John A. Caswell, Richard A. Donnenwirth, Robert L. Dutton, Ralph W. Graham, Fred G.

Hammond, William J. Jackson, Ward A. Knights, Paul W. Miller, William E. Ramsden, Edward A. Tulis, Jr., Charles A. Sullivan, and Harold D. Yarrington.

Chaplain Supervisors—Robert C. Alexander, Arthur H. Becker, Clarence L. Bruninga, Peter T. Burks, Emil M. Hartl, Kazuhiko, Higuchi, John R. Howard, Oscar G. Phillips, Kenneth E. Reed, Robert J. Williams, and Merlin W. Zier.

Six new mental hospitals and two correctional institutions were approved as training centers, bringing the total number of Institute Training Centers to forty-two. They include sixteen general hospitals, twenty-one mental hospitals, two correctional institutions, and three specialized institutions.

Also at the Board meeting Dean Walter G. Muelder of Boston University School of Theology presented a report of the Sub-committee on Seminary Affiliation. He pointed out that it became necessary to re-evaluate policy on seminary affiliation because of the number of requests from seminaries across the country to affiliate with the Institute.

Several papers were presented by supervisors. These will be published and made available early in 1961, at the cost of publication. Dr. Joseph Woodson of the Massachusetts Mental Health Center read a paper on some comparisons between the hospital and parish ministries. Dr. John Billinsky presented a paper on "The Objectives of Clinical Pastoral Education." Other papers included "When You Minister to a Woman" by Chaplain Helen Terkelsen and "The Emotional Growth of Students in Clinical Pastoral Training" by Dr. Myron Klinkman.

The program provided for workshop groups to discuss aspects of individual training centers after the supervisor had presented the philosophy and practice of his program to the group.

The Conference offered another opportunity for the supervisors to study together some of the real concerns of clinical pastoral education.

THE REV. JOHN I. SMITH, *Executive Secretary*

Institute of Pastoral Care
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Worcester 1, *Massachusetts*

Annual Conference of Supervisors of the Council for Clinical Training, 1960

The Annual Conference of Supervisors of the Council for Clinical Training, Inc., met at the Hotel Pierre L'Enfant in Washington, D. C., from October 23 to 26, with one hundred delegates from the Council's training centers and member seminaries, as well as denominational representatives, attending. The main focus of attention in the panel and work-

shop discussions was on the extensive work of the Special Study Committee and a revision of standards which will be enacted in final form next year.

The outstanding feature was the banquet on Wednesday evening when Dr. Robert Elliott of Perkins Theological Seminary delivered a stimulating paper on "Guilt and Forgiveness." The discussants of this paper were the Rev. Ralph D. Bonacker, Rector of the Church of St. John the Evangelist in San Francisco, and the Rev. Edward F. Dobihal, Jr., Director, Protestant Clinical Pastoral Training at Saint Elizabeths Hospital in Washington, D.C.

With the Council's continued emphasis on quality of supervision, its Accreditation Committee, in long sessions three days prior to the opening of the Conference, reviewed twenty-four candidates, accrediting twelve as new supervisors in addition to certifying two others as clinically trained chaplains.

KEITH W. KEIDEL
Program Chairman

Council for Clinical Pastoral Training
475 *Riverside Drive*
New York 27, New York

BOOK REVIEWS AND NOTICES

Edited by The Rev. Rollin J. Fairbanks

The Christian Shepherd: Some Aspects of Pastoral Care: Seward Hiltner; Abingdon Press, New York, 1959. 190 pp. $3.00.

The author has taken the comprehensive understanding of the shepherding perspective of the work of the minister and the church and has applied it to several specific areas and dimensions of Christian shepherding about which he has not previously written in such books as his *Pastoral Counseling* and his *A Preface to Pastoral Theology.*

With the careful use of case material securely buttressed by a thorough knowledge of the extensive research done in these several areas, he lucidly and succinctly discusses the shepherding task of the pastor in such problems as grief, family relationships, class structure, "organization men's" problems, "rebel's" problems, housewives' problems, etc. His discussions of class structure, comtemporary organizationalism, religious and lay rebellions, and the care of housewives, to my knowledge, make the book a unique book inasmuch as not only are these problems not dealt with in other of Hiltner's writings but they are not dealt with specifically in any of the literature on pastoral care as such.

The working pastor will find this book an effective clue to some of the inarticulate difficulties of his people, and the working chaplain will find new points of departure for understanding pathology by reading this book.

The cultural overview which Hiltner is developing in this book is a helpful antidote to the hyperindividualism with which pastoral counseling sometimes is afflicted.

WAYNE E. OATES

Christ and Freud: A Study of Religious Experience and Observance: Arthur Guirdham; George Allen and Unwin, London (Macmillan, New York), 1959. 193 pp. $4.75.

A reviewer's first question about a volume with a title such as this is whether the author is serious and well-informed or glib and ill-prepared. Dr. Guirdham (author of the intriguing earlier book, *A Theory of Disease*) is certainly a serious writer. He proposes "to estimate to what extent religious factors are important in relation to psychiatric conditions, and more especially to neurosis." His competence to write such a study may be gauged from the formal facts: an English psychiatrist of psychoanalytic persuasion with sufficient clinical experience to enrich his pages with easy references to the experiences of a practitioner. There is no clear-cut expression of his religious or theological position. He does, however, reveal (again in a rich supply of anecdote and allusion) that he is no stranger to

the teachings, worship, and life of the Church. In neither area however—psychiatry or religion—is he a complacent communicant. He makes clear within the first chapter that he will be critic of both psychiatry and religion. His criticism, however, has but a single target. This target, which he finds revealed in aspects of both religion and psychiatry, is "the excessive and painful consciousness of (one's) own personality." Over against this he offers an answer which he finds implicit in religious experience, namely, the processes that lead to self-annihilation. Typical of this basic thesis of the book are the following: "We will suffer from the diseases of personality so long as we emphasize personality . . . We cannot shed our symptoms because we cannot shed ourselves." In speaking of the cooperation of priests and doctors, he writes: "I cannot see that there can be any common basis other than a belief in the necessity for self-annihilation."

This philosophic concept of self-annihilation is clearly not simply suicidal. It appears to be derived from several sources. Guirdham finds it first as the converse of what he generalizes from his clinical experience with neurotic illness. Neurosis is defined as including anxiety states, obsessional conditions, hysterical conditions, and depressions reactive to adverse circumstances, chronic anxiety, constitutional factors. The common characteristic of such pathological states is "an increased awareness of separate identity as individuals." The concept of self-annihilation (total submission to the Absolute) is further derived from his reflections on the essence of the Christian experience uncontaminated by theology, clericalism, historicity, and "Jewish elements." Finally, and perhaps most fully, he finds this concept most fully exemplified in Buddhism and Hinduism. In several passages he bursts out of any exclusive attachment to Christian theology noting that inquisitions, orthodoxy, some doctrines represent the anxious attempt of questioning ecclesiastics to bolster a shaky and frustrating religious system. These sweeping points draw heavily from the classic Freudian interpretation of religion as a socialized obsessional neurosis. Guirdham returns to his clinical interests: "The limited and fragmented Western approach to God has a disruptive effect on the psyche. The Eastern techniques render the total submission to the Absolute a much more immediate proposition. To merge one's personality in the Infinite in the course of earthly existence is to render it relatively exempt from the stresses which produce symptoms in those too aware of the apartness of their individualities." In such a view Guirdham can find reputable company. He cites a few: Jung, Huxley, Isherwood. Unfortunately, he also sets down the conversational reflections of gossiping practitioners (the Welsh psychiatrist who muses that his fellow countrymen would be less plagued by neuroses if they have remained Roman Catholics rather than becoming adherents of 'chapel religion').

This book is not designed for reading by the novice in religion or psychiatry. It has little value for the practicing pastor or psychiatrist. For those who can draw upon a fund of experience and who can measure Guirdham's critical eclecticism against their own systematic theoretical knowledge in the personality sciences and in theology—for these the book has many rewards. There is, for example, the intriguing comparison to be made to the work of Boisen, whose approach to the problem of Christ and Freud was through study of psychosis—rather than neurosis. (The

author never mentions Boisen, nor Oates or Wise—all of whom occur to mind in reading.) The comparison led this reviewer to hypothesize that American pastoral psychology—so profoundly influenced by the graduates of clinical pastoral training with psychotic patients—has assimilated the Freudian criticism of religion with far more equanimity than Dr. Guirdham displays. Experience with the crisis of psychosis has imprinted American pastoral psychology with an awareness of undifferentiated, alien primary processes with which the ego and the society struggle to achieve a tolerable compromise. There is little of this quality to be found in Guirdham's pages, although he does use the test of social utility to differentiate between delusion and mystic religious experience. Similarly, the restriction of his interest to neurosis alienates Guirdham's work (and those of Freud cited, too) from the body of theory and data concerned with religion and character formation (and character disorder). Here, one is struck by the comparison with such works as those of Aichhorn, Wilhelm Reich, and Erik Erickson. As stimulus for such reflections expressed in a happy, lucid style one can recommend the volume.

THOMAS W. KLINK

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Psychiatry and Common Sense: C. S. Bluemel; Macmillan, New York, 1954. 251 pp. $3.50.

As the title of this book suggests, the author seeks to make psychiatric understanding of personality comprehensible in "common sense" terms. The book is written for "the inquiring layman and for the physician who is unfamiliar with psychiatric terms."

Without recourse to the more technical terminology of psychiatry, which the author feels is sometimes obscure, he uses what he calls more "simple language." This careful avoidance of technical language may be for some an attractive feature of the book. For others it may be found as a limitation. For example, in place of the terms "integration" and "disintegration" Dr. Bluemel uses the terms "organization," "non-organization," and "disorganization."

Throughout the book strong emphasis is placed upon biological and hereditary factors in personality. In an initial chapter on "organization" the author describes in simple and quite readable terms some of the factors involved in the infant's growth and efforts toward organization.

Under the heading "non-organization" emotional characteristics of "infantilism," "fear and aversion," "indecision," "aversion," "agressiveness," and "hypochondria" are dealt with in a short chapter. A number of symptoms illustrating these states are described, for the most part in non-dynamic terms. "Non-organization," or poor organization, is viewed as preliminary to disorganization experienced in neurotic illness.

In his discussion of neurotic illness in a chapter entitled "The Nature of Disorganization" the author gives a description of the range of symptoms which result from reactions to stress, which may be environmental, physical, emotional—anything which "exceeds the individual's biological tolerance." The author concludes that disorganization, which occurs in different degrees, is not a disease process. Disorganization is an interruption, or disruption, disturbance, or disorder of function. Functions disorganized by

reaction to stress are not necessarily lost, but may be restored. The patterns of disorganization are discussed in terms of disorganization of "inborn functions" and the disorders of "acquired responses." The symptoms of disorganization are described with little explanation as to cause and very little reference to emotional factors involved.

Psychosomatic disorders are briefly discussed. Emphasis is given to the necessity of seeing the "whole" person in understanding the true nature of the psychosomatic illness. The psychosomatic disorders are regarded as primarily somatic in cause, with the psychological factors serving to complicate or aggravate the difficulty.

In mental illness the primary disturbance is with emotions and mind. As a preliminary to his discussion of mental illness the author briefly describes auxiety neurosis, tension state, and insomnia. The discussion of the major psychoses (melancholia, mania, paranoia, schizophrenia, the constitutional psychopathic state, senile dementia, and general paresis), while very brief, is simple, clear, and very readable. For one unacquainted with mental illness this description will serve as a useful introduction.

A short chapter on alcoholism includes descriptions of some of the various kinds of "drinkers": the "self-conscious drinker," the "tense and agitated drinker," the "depressed drinker," and the "psychopathic drinker." The program of Alcoholics Anonymous is applauded as probably the most successful approach to dealing with the problem of alcoholism.

The concluding chapters of the book contain suggestions for self-help or "personal psychotherapy." The importance of self-acceptance, an attitude of flexibility, finding constructive channels and outlets for hostility and aggression is pointed to as aiding "reorganization." Religion is treated in a few very short paragraphs.

A "glossary" of medical and psychological terms concludes the book. The "glossary" should be quite helpful to the person not too familiar with psychiatric terminology.

What is probably the chief merit of this book—namely, its brevity and readability—is also its chief limitation. The usefulness of the book will depend on the background of the reader. For the pastor, for example, who would like something of an introduction to personality, the book will prove useful. However, the book is written from a viewpoint which stresses the hereditary, constitutional, or biological factors in personality, with little recognition given to the emotional factors of personality development as understood by dynamic psychiatry. But more serious still is the fact that many of the changes of attitude proposed in the section on "personal therapy" are precisely the changes which disorganized and troubled people cannot make on their own without extensive assistance from a therapeutic relationship.

JOE E. CALDWELL

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Faith Healing and the Christian Faith: Wade H. Boggs, Jr.; John Knox Press, Richmond, Virginia, 1956. 216 pp. $3.50.

This book is a sincere effort to appraise the various practices of spiritual healing. The author calls it "an attempt to focus the light of the

Bible upon the problems raised by the modern faith healing movement." Actually there is in this book a good deal more material than this would imply. The first part is given over to a description of the various faith healers and their philosophy as expressed in their writings together with a consideration of the results they achieve. This latter makes dismal reading. Other chapters go to the Bible for the answers to such questions as "Should mature Christians seek medical help?", "Does all sickness result from the sin of man?" "Does God will perfect health for every one?"

The last section is entitled "What should the Church do about healing?" In this is set forth a positive Christian philosophy of health and there follow sections on prayer and faith with relation to health. The final chapter is on what the Church can and should do to promote good health. The book is thoroughly annotated and has an extensive bibliography.

As can be seen from the above outline, this is a comprehensive and ambitious work. How well Dr. Boggs succeeds in his announced aim is left for each reader to judge for himself for in the field of faith healing opinions differ on all these subjects. This reviewer feels that he has succeeded very well in that he has exposed some of the more radical healers while leaving plenty of room for prayer and faith to operate in the restoration of the whole man. His positive philosophy of health is also the Christian philosophy of life and is stated as follows: "The will of God for mankind is Christlikeness in character, and everything else, including sickness and health, derives its significance and value in relation to that divine goal."

This book is recommended to all who are interested in the Church's role in the treatment of the sick, particularly those who feel that the practices of some of the faith healers are open to question.

G. DOUGLAS KRUMBHAAR

OUR REVIEWERS

Wayne E. Oates is Professor of Psychology of Religion at the Southern Baptist Theological Seminary, Louisville, Kentucky . . . *Thomas W. Klink* is Chaplain and Coordinator of Graduate Studies in Religion and Psychiatry, at The Menninger Foundation, Topeka, Kansas . . . *Joe E. Caldwell* is Chaplain Supervisor at the Boys Industrial School, Topeka, Kansas . . . *G. Douglas Krumbhaar* is Canon Pastor at St. Paul's Cathedral, Boston, Massachusetts.

NEWS AND COMMENTS

Chaplain William B. Spofford, Jr., resigned as Chaplain Supervisor at the Massachusetts General Hospital, Boston, and from the faculty of the Episcopal Theological School in Cambridge, effective October 15, when he assumed his new duties as Dean of St. Michael's Cathedral, Boise, Idaho.

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Central State Hospital in Lakeland, Kentucky, and Arkansas State Hospital in Little Rock are both looking for chaplains, preferably with Chaplain Supervisor status.

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The Academy of Religion and Mental Health will hold its second annual meeting on January 19 and 20, 1961, at the Hotel Biltmore in New York City. Featured speakers will be Karl A. Menninger, M.D., at the luncheon of January 19 and Rollo May, Ph.D., at the luncheon on January 20. Harvey J. Tompkins, M.D., will deliver the Presidential Address at the opening session at 9:15 A.M., Friday, January 19. Other features of the program include a review of the Fourth Academy Symposium on "The Place of Value Systems in Medical Education" and panel discussions on "Mass Communications in Mental Health," "The Psychology of Addiction," "Working Assumptions between Science and Religion," and "Emotional Problems of Children and Young People."

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The Pacific School of Religion, Berkeley, California, is offering a Pastoral Counseling Service, under the direction of the Rev. Robert C. Leslie, Ph.D. This is a service for the community where troubled persons may find personal help through psychological and religious counseling.

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The Institute of Clinical Pastoral Training, 3785 Fairmount Avenue, San Diego 5, California, was founded by a group of professional people representing medicine, psychiatry, psychology, law, social work, education, and theology, for the purpose of training clergymen in the skills and techniques of pastoral counseling. The Rev. Charles C. Howse, M.A., S.T.B., is Executive Director. The programs of the Institute serve four major functions: (1) to provide the parish minister with an introduction to the fundamentals of pastoral counseling that may be applied by him to his work in his own church or parish; (2) to provide the minister with a more intensive course with emphasis on clinical training that may be used regardless of the assignment of the minister in any of the numerous fields and endeavors of his profession; (3) to provide intensive training to those ministers who desire to make institutional and counseling work the primary goal of their ministry; and (4) to provide comprehensive training for parish ministers, seminarians, and pastoral counselors in counseling and pastoral care in a parish setting. For further information write to the Institute at the address given above.

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The Air Traffic Industry now is prepared to embrace the reduced-rate clergy program by the establishment of the Airlines Clergy

Bureau, which received recognition by the Civil Aeronautics Board on September 1, 1960. The Airlines Clergy Bureau serves both ministers and airlines seeking the best service for the traveling clergyman. Complete service is available from New England to Florida and the Bahamas, and negotiations are in progress to cover six central states and all the western states from Alaska to Arizona before January 1, 1961. The reduced rate is 50 per cent of regular one-way first-class or coach fare. The Bureau has negotiated with 39 independent hotels and motels and four hotel chains for special consideration of 25-per-cent discount off regular room rate when Identification Card is presented. Applications may be obtained by writing to the Airlines Clergy Bureau, Municipal Airport, Sacramento, California.

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The Religious Counseling Center, Grand Rapids, Michigan, announces a Counseling and Referral Workshop, December 31, 1960, January 1-2, 1961. The purpose is to bring together a group of sixty persons in business, professional, church, parish, school, home, and interviewing who would like to learn more about counseling and referral to other counselors. Among the leaders will be the Rev. H. Walter Yoder, Founder and Pastoral Director of the Center and Founder and President of the Michigan Association of Religious Counselors, the two organizations which are sponsoring the Workshop.

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The National Association on Service to Unmarried Parents has just issued its *Maternity Home Directory,* 1960. The price is $2.00, and orders may be sent to Mrs. Emily Gould, 120 Grand Street, White Plains, New York.

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A small booklet, "Healing by Prayer," by the Rev. G. Douglas Krumbhaar, has been published by the Forward Movement Publications, 412 Sycamore Street, Cincinnati 2, Ohio.

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The sixteenth printing of the pamphlet, "For Those Who Mourn— A Message to the Bereaved and to All Who Would Face the Fact of Death," has been issued by the Forward Movement Publications, 412 Sycamore Street, Cincinnati 2, Ohio.

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"The Way of Man According to the Teachings of Hasidism," by Martin Buber (with a Foreword by Maurice Friedman), has been published as Pendle Hill Pamphlet 106 (Pendle Hill, Wallingford, Pennsylvania). Price, 35 cents.

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An 8-page booklet, "To the Anglican Nurse," with a Foreword by the Bishop of Lichfield, published for the Hospital Chaplaincies Council by the Church Information Board, Church House, Dean's Yard, Westminster, S.W. 1, was "written in order that it may be of some help to a girl who is a practising member of the Church of England and who has decided to take up nursing as her career." Price 3d.; per 100: 1 pound.